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ABSTRACT

Articles in seven newsletters of the Intercultural Development Research Association's Mental Health Research Project emphasize community mental health, human, and child welfare services to Mexican Americans, particularly in Texas. Topics include social policy formation in child welfare services, utilization of community mental health clinics (CMHCs) by Mexican Americans, Texas state government reorganization to better serve Mexican American mental health needs, Mexican American women as subjects and investigators of social science research, depression in Mexican American women, psychiatric treatment relevance for Hispanic inpatients, responsibilities of CMHCs to Mexican American children and other underserved youth, sociopolitical genesis of CMHCs, status of special populations in the Texas Commission on Alcoholism State Plan, overview of patients' rights in mental health services, service needs of Mexican American elderly, use of Mexican American paraprofessionals in CMHC staffing, eliminating service barriers for Mexican Americans in mental health treatment, Texas legislative response to mental health issues, and planning strategies for mental health services for Mexican Americans. Report of a conference sponsored by the Research Project summarizes key mental health concerns emerging from conference workshops on service utilization, treatment, service planning, and patients' rights/advocacy. Tables, graphs, and bibliographies accompany several articles. Updates on federal legislation occur in four issues. (LFL)

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The IDRA Newsletter of the Mental Health Research Project
1979-1981

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RC
NEWSLETTER OF THE MENTAL
HEALTH RESEARCH PROJECT

FALL 1979

THE MAKING OF SOCIAL POLICY IN THE U.S. - SOME ISSUES IMPORTANT TO HISPANICS

By Dr. Blandina Cárdenas Ramírez

Of the sixty-four million children under the age of eighteen in the United States, approximately 11.2 percent are of Hispanic origin. Already Hispanic children represent the largest minority group among children in the nation. Given this reality and the fact that this group of children is overrepresented among populations in need, it is important to question the degree to which social policy affecting the well-being of children in the United States is developed with awareness of and particular attention to the needs of Hispanic children.

In examining the question, it first is necessary to define (1) the parameters of social policy affecting children, and (2) the policymakers. The process of policymaking for children in this country is influenced by one predominant factor -- children do not vote. They cannot express their own self-interest or the interest of their peers. Thus, while the aged, the handicapped, and the businessman can demand some degree of accountability on the part of their elected representatives, children's needs are proxied by professionals and advocates.

During my tenure as Commissioner of the Administration for Children, Youth and Families of the Department of Health, Education and Welfare, I had an unprecedented (for a Hispanic) opportunity to begin to understand and play a key role in the process of shaping policy as it affects the children of our country. This is not to say that my role was decisive. Policy affecting children in this country is made by individuals far more powerful than the Commissioner of ACYF.

Key Senators and Congressmen and women control, through committee chairmanships, much of what happens. Senator Russell Long, for example, has jurisdiction over all matters pertaining to Medicaid, AFDC (Aid to Families with Dependent Children), child welfare services, day care, and other social

services through the Senate Finance Committee which also has responsibility for this country's oil and gas policies. Senator Edward Kennedy has jurisdiction over matters of child health administered by the Public Health Service. Education issues are the jurisdiction of committees led by Sen. Pell of Rhode Island and Congressman Carl Perkins of Kentucky. For the most part, these committees tend to be overrepresentative of the Northeastern and Midwestern United States, states which only recently have begun to recognize a Hispanic presence.

A corollary set of Appropriations Committees also plays an important role in the setting of social priorities. All of these committees are further influenced by often extremely powerful staffs, most of whom are graduates of Ivy League Universities with little exposure to Hispanics, although in many cases with a predisposition to be responsive.

The Executive Branch of Government, through the Domestic Council, the Office of Management and Budget, and the Departments of HEW and Agriculture, exercise an important veto power, both absolute and procedural, over policy affecting children. The Justice Department and the Supreme Court also set important policy direction.

Outside of government, a very active and persistent children's lobby has significant influence over the making and unmaking of social policy affecting children. The lobby includes advocacy organizations that have existed for over a century, such as the Child Welfare League of America, the American Pediatrics Association, and several that were born out of the heightened expectations of the 1960's, such as the Children's Defense Fund and the Black Child Development Institute. These organizations are impressive in their commitment to the well-being of children, and equally impressive for their knowledge of and diligence in the process of policymaking.

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CHILDREN'S POLICY

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The "civil rights coalition" of labor and minority groups, women, and the elderly, is another important force in the making of domestic social policy, but the truth is that only a few Hispanic individuals on very few occasions have ever participated in that informal but effective coalition, and that participation has usually been on a one-shot basis. We simply are not a part of the mainstream work of that coalition; moreover, few Hispanics are aware of its role in the making of social policy.

An additional force in the policymaking process is represented by those who control the generation and dissemination of data - data which describe and data which explain. Generally speaking, the generation and dissemination of data is controlled by the bureaucrats of the federal and state governments, of universities and of foundations. Data seldom play a decisive factor in the making of policy, but the absence of data inevitably leads to an absence of serious consideration of an important policy issue.

The absence of data and data analysis on Hispanic children is a major failing of the government, academic and foundation complex. At best, data describing the condition of minorities in general may be suspected of including Hispanics.

Congressman Edward Roybal's successful effort to require legislatively that all agencies of the federal government collect data on Hispanics, Public Law 94-311, is a major victory for the Hispanic community. But this law, passed in 1976, is yet to be implemented, and as it is implemented, it must survive the strong sentiment in the Congress and the Office of Management and Budget to curtail rather than expand data collection. It is likely that federal agencies will develop strong rationale for delimiting data collection on Hispanics, particularly since the policy shops which make these decisions are usually devoid of Hispanic staff and do not generally consider Hispanics as part of their constituency.

It is clear that Public Law 94-311 can fulfill its promise to the Hispanic community only if the community diligently and consistently monitors the law's implementation by each of the governmental departments. Unfortunately, such monitoring takes a degree of expertise which is scattered and only differentially available within the Hispanic community. Financial resources to support such monitoring are essential and yet to be cultivated by our community.

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SOCIAL POLICY PARAMETERS

The parameters of social policy for children are extensive - health, nutrition, education, child protection and child welfare, traditionally; and more recently, fair trade practices, consumer protection, and environment. The basic policy tension in relation to children has always revolved around the rights and responsibilities of the family in relation to children, juxtaposed with the rights and responsibilities of society and its institutions in relation to children. It is not a frivolous tension, although it is one which far too frequently is treated simplistically or is exploited by persons on either side of an issue.

This country has developed impressive policies which speak to assuring children's access to health, nutrition, education, child welfare and child development services. There exists in effect a "policy floor" upon which to build the full complement of services which would ensure each child an equal opportunity to develop physically, intellectually and socially, regardless of his or her family's capacity to pay for, or otherwise provide for, those basic needs.

The problem lies in that those policies seldom reach the universe of children who need the protection of those policies. Head Start, for example, is a comprehensive child development program for children of low-income families. In spite of extremely restrictive eligibility criteria, the program serves only 20 percent of the eligible population. If eligibility criteria were more reflective of actual need, the percentage of children in need receiving services would be miniscule.

The Early Periodic Screening Diagnosis and Treatment Program was written to provide health protections to children eligible under very restrictive criteria, but to leave to the states the decision to include children fitting a more inclusive definition of need. Nonetheless, the program should be serving

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The NEWSLETTER OF THE MENTAL HEALTH RESEARCH PROJECT serves as a vehicle for communication with professionals, laypersons and the general public concerning issues related to mental health and mental retardation. Persons interested in publishing articles contained herein should contact the editor.

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CHILDREN'S POLICY

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between 10 and 13 million children nationwide even under the most restrictive eligibility criteria. HEW estimated that a total of two million assessments were conducted last year.

There are many issues relative to the substance of policy for children which need to be examined in relation to Hispanic children. Most programs are insensitive, for example, to the great potential for developmental support which Hispanic children can and do receive not only from the nuclear family, but from the extended family. Adoption support programs, for example, fail to recognize, subsidize, or otherwise reinforce the many informal adoptions which occur in our community and which can serve as either a temporary or permanent support system for the child, without the child losing his/her familial or cultural identity.

Perhaps more important to Hispanics in the immediate sense, however, are issues of a structural nature relative to the setting of policy for children. Structural issues determine how the benefits of a policy are to reach the intended beneficiaries, and can be far more impactful on an underserved population of Hispanic children. Some of these structural issues are:

The formula for the distribution of resources among the states.

Head Start and other programs for poor children call legislatively for the utilization of a two-part formula for the distribution of Head Start monies among the states. States are to receive money (funded directly to local grantees and not through state government) on the basis of the number of children in poverty and the number of children on AFDC. Thus, children in states with a liberal AFDC program have a greater opportunity to access a Head Start program than children living in a state with restrictive AFDC policies.

The formula for the distribution of resources among the states is an important consideration for advocates for Hispanic children when one considers the large numbers of Hispanic children living in southwestern states with restrictive AFDC policies.

The federal/state role and authority in the implementation of a policy.

The tension between federal and states' rights and responsibilities is ever-present in the making of children's policy, whether at the legislative or regulatory stage.

Children's services with a longer history of governmental activity, such as child welfare and education, are generally considered the purview of the states and have entrenched bureaucratic and advocacy systems reinforcing that tradition. Those governmental activities which were begun in more recent times, particularly programs specifically aimed at poor and minority children, generally have a history that premised a strong federal role and responsibility. Advocates for poor and minority children seek to reinforce that strong federal role in most policies affecting children.

The issue of state/federal role and authority becomes operationalized around such questions as: Who decides what children are to receive the service or protection? Who decides who is to provide the service or protection? What are the standards for state accountability for the provision of services or protections?

When states are given the prerogative to determine who is eligible, income criteria may vary from poverty level to 115% of the states' median income, or eligibility may be linked to AFDC participation, which in many states, excludes children from two-parent families, regardless of income.

The relative support for capacity building activities that accompany the services policy.

Most federal policies are written into law with some understanding of what it takes to introduce and maintain a program of service. Thus, most federal programs provide for support of research and development, training, evaluation, and other discretionary activities which may be needed to maintain the activity.

The capacity building efforts of the federal government are awesome. Approximately 1500 child welfare workers are trained every year with federal monies; 7,000 individuals are trained yearly in the field of rehabilitative services; doctors, nurses, special education specialists, gerontologists, mental health professionals--the list is endless for every field of human endeavor. And these training programs are not new; many have existed for 30 years or more.

The questions for those of us who advocate for the well-being of Hispanic children and their families are: How many of the tens of thousands of persons being trained annually by the federal government are Hispanic? And of the non-Hispanics being trained, how many are being trained for work in a community with substantial numbers of Hispanic children?

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INFANCY: THE BEGINNINGS OF MENTAL HEALTH

by Jill Schlansker, Ph.D.

Which Infants Are at Risk?

Mental health services aimed at primary prevention struggle to identify early signs which are predictive of later emotional, social, or intellectual disabilities. The identification of risk in infancy is made difficult, at least in part, by old notions of development which assume that certain symptoms or causes evident at one point in time imply certain outcomes at a later point in time. Thus, oftentimes the failure to identify clear genetic or biological damage to infants who demonstrate sensory or behavioral disorders has been attributed to poor or inadequate diagnostic techniques rather than to the possibility of more complex causes and developmental processes.

The fact that some infants who experience complications do not evidence later disabilities while others with identical medical histories do, suggests that more stable or chronic conditions play a powerful role in development. Premature infants, for example, do not necessarily show intellectual deficits in the preschool years when they come from middle or upper class families; they usually do show delay or deficits in the case of lower income families. The environmental conditions associated with socio-economic class have an ongoing impact, whereas an event like prematurity does *not* necessarily.

Infant and Environment: Mutual influences

Until recently, research related to environmental influences on the child concentrated on identifying characteristics of the parent or of the home which were associated with poor development. Among the more extreme examples of this literature are studies in which parental factors such as personality characteristics, intelligence, personal histories of abuse, social and economic background, parenting skills, and attitudes toward children have all been associated with abusive or neglectful parents. However, these studies typically have been retrospective investigations; that is, abusive parents have been described in some common ways once they are known, but all parents who could be described identically do not necessarily abuse or neglect their children.

A number of more recent studies suggest that certain characteristics of the *child* may contribute to his or her own maltreatment. Many studies of normal, healthy infants in the last half decade have demonstrated that the infant is far more influential in the establishment of interpersonal relationships and

interaction patterns than once was thought. There is considerable research evidence now which indicates that even before birth the young infant elicits varying kinds of responses from his/her mother, responses which may either assist the infant's adaptation or make adaptation difficult. Also, a variety of factors have been found which may predispose certain parents to neglect or abuse their child, e.g., low birth weight, prematurity, medical illnesses, prolonged separation of the infant from the parent(s), and very difficult and irritable temperament. While no studies have yet attempted to explore the match between parent and child characteristics in predicting abuse or neglect, observations have been reported of children being battered by different and unrelated caregivers, in addition to their own parents. Apparently, then, both infant and parent characteristics can contribute to abuse or neglect.

Needs for Primary Prevention

Infants who are not able to develop secure attachments to parents show maladaptive developmental patterns. A young infant may evidence maladaptation by extreme feeding difficulties or avoidance of interaction with parents. By one year of

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IDRA is pleased to announce that Mr. David G. Ramirez (center) has been selected to serve as project director of the Mental Health Research Project. For the past year, Mr. Ramirez has served as field researcher for the project. Also pictured are John Estrada (l), member of the MHRP State of Texas Advisory Committee, and Dr. José A. Cárdenas (r), IDRA executive director.

INFANCY

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age, if a secure attachment has not formed, infants show a lack of curiosity about their environment. They do not perform well on developmental tests, and they cannot be calmed and comforted in stressful situations. The aim of primary prevention in infancy becomes one of assisting the infant and family at risk to develop and maintain a way of interacting with each other that allows each individual opportunities for growth.

Since both biological and environmental factors place an infant at risk, both kinds of factors need to be considered in the evaluation of risk. Infants, for example, who require intensive hospital care after birth should be screened routinely for possible hearing and sight impairment. These infants and other infants at risk for biological reasons should also be evaluated for feeding and sleeping problems, lack of response to human stimulation, and other behaviors which present difficulties to parents and caregivers. Likewise, parents or primary caregivers who may have difficulty in providing adequate and appropriate care for an infant need to be identified and supported as individuals with their own needs and as caregivers. In some cases, this support can be initiated prior to the birth of the baby, e. g., for low-income parents, teenagers, known drug abusers. In other cases, the risk factors may not become apparent until the time of

birth or shortly thereafter, e.g., premature delivery, failure of the infant to thrive.

The assessment of risk in infancy requires an evaluation of the family as a unit, of the infant and of his or her caregivers as they *together* impact the development of the child. Family assessment should be made before the birth of the infant when possible, and soon after birth when a risk factor does not manifest itself until that time. The identification of risk should be a major concern of professionals who contact prospective and new parents. A wide range of expertise is needed for assessment and support of the family, including child developmentalists, psychologists, obstetricians, pediatricians, nurses, social workers, and nutritionists. Furthermore, professionals who provide assessment and support services must be aware of cultural characteristics of the families with whom they work. Without a knowledge of the values and behavioral patterns which are "normal" for parents, grandparents and other family members in given ethnic groups, the professional is certainly hard put to make valid evaluations of risk and to capitalize on cultural strengths as strategies for support.

While the mobilization of these resources is difficult at best in most communities, the network for family support beginning during pregnancy or early in the first year is essential if we are to make a genuine effort toward the primary prevention of mental health problems.

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Monies spent on evaluation of every conceivable activity may well exceed the human service budgets of many small countries. These evaluation activities furthermore have been on-going for many years and *have* been impactful in that they broadcast to policymakers the values of the discipline and call attention to the true goals and objectives of the program.

The questions for those of us who would advocate for the well-being of Hispanics are simple: Do those evaluation activities ask the important policy and programmatic issues relative to Hispanics, and if so, what is done with the data? Questions relative to who is doing the evaluation, as well as to the appropriateness of the methodology are important additional issues.

If the capacity building goals set by the Congress in passing child focused legislation are to be met, it will be necessary to provide for the special capacity building needs attendant to the service and protection of Hispanic children. This can occur only when the policymaking process and policymakers are informed and made accountable by the Hispanic community.

CONCLUSION

On the whole, the making of social policy in this country works remarkably well. It is difficult to envision a democratic process that could better reconcile the broad-range of sophisticated and diverse interests. But the system cannot work for Hispanics in this or the next generation unless we create, through understanding and diligence, our own opportunity to participate effectively.

The oldest and truest American dream is not a materialistic one, but an idealistic one -- the notion that the common man and woman might have some control over the form and function of the social policies and institutions which govern their daily lives. To realize that dream, Hispanics must expand their political effectiveness beyond the election of candidates to the shaping of social policy. A good place to begin is with policy affecting our children.

*For further information see: Steiner, Gilbert Y., *The Children's Cause*, Washington, D.C.: Brookings Institute, 1976.

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WHERE ARE THE CHILDREN GOING?

by Fred Fiedler, Ph.D.

In 1970, there were 2,861,253 children (aged 0-12) and 1,766,029 youth (aged 13-20) in Texas. The populations of children and youth are estimated to have changed to 2,372,968 and 2,890,885, respectively, by 1978. Various estimates are available of the proportion of all children and youth who are in need of mental health services (treatment for mental health illness and the emotionally disturbed) and mental retardation services. The Texas Department of Mental Health and Mental Retardation (TDMHMR) estimates that 11.5 percent of the State's population of children and youth are in need of mental health services, and 0.4 percent are in need of services for the

mentally retarded (severely and profoundly, or moderately retarded). Thus, in 1970 well over one half million of the State's children and youth were in need of mental health services, and about 18,500 were in need of mental retardation services. By 1978, these figures may well have increased to 600,000 children and youth in need of mental health services and over 21,000 in need of mental health retardation services.

Providers of MHMR services

A large number of state and local private, public and voluntary agencies and groups contribute to the provision of needed mental health and mental retardation (MHMR) services to children and youth in Texas. In the private sector, these services are provided by psychiatrists and social workers. Among the public providers are the Texas Youth Council, Texas Education Agency, Texas Rehabilitation Commission, Department of Human Resources and Department of Health.

The Texas Association for Retarded Citizens and the Texas Council for Exceptional Children provide referral and counseling services for children, youth and their families, but provide no direct services.

A major provider of direct services, of course, is TDMHMR and the department's Community Mental Health/Retardation Centers (CMHCs).

MHMR services provided by CMHCs

Information reported by TDMHMR since 1973, indicating the number of children and youth provided

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TABLE 1

Children and Youth Receiving Mental Health (including Alcoholism Treatment and Drug Abuse) Services from CMHCs in Texas

FY	Children (Ages 0-12)	Youth (Ages 13-20)	Total All Clients	Percentage of all MH Clients who are Children & Youth
1973	6,077	10,615	59,481	28.1
1974	6,627	13,382	74,744	26.8
1975	6,645	14,172	82,280	25.3
1976	6,304	12,696	83,601	22.7
1977	7,268	12,703	85,336	23.4
1978	8,284	14,489	96,554	23.6

mental health services at CMHCs, is compiled in Table 1 (pg. 6). These figures show an increase of 36 percent from the 16,692 children and youth served at CMHCs in 1973 to 22,773 in 1978. During this same time period, however, the total number of persons of all ages who received these services increased at the even faster rate of 62 percent (from 59,481 in 1973 to 96,554 in 1978). As a result of the different rates of increase, mental health services to children and youth have been a decreasing percentage of all CMHC mental health services over recent years (from 28 percent in 1973 to 24 percent in 1978).

Table 2 (pg. 7) represents the mental retardation services provided to the State's children and youth over the past years. As can be seen from the table, the number of both children and youth receiving mental retardation services from CMHCs has declined (5,782 in 1973 as compared to 5,009 in 1978), while the total mental retardation caseload (number of persons receiving services) has increased. Thus in 1973, children and youth were 75 percent of the total mental retardation caseload, and in 1978 they were only 53 percent of the caseload.

It is evident that both mental health and mental retardation services provided by CMHCs in Texas have progressively de-emphasized services to children and youth over the past six years.

Where are the missing children?

IDRA's Mental Health Research Project is interested in gaining an in-depth understanding of the dynamics involved in the general shift of the CMHC caseload away from children and youth. The concern

is to determine whether the services are being delivered by other providers or whether the services, and the children and youth as well, are missing from the mental health system.

Are the children and youth missing from the mental health system because of:

- the trend from residential treatment (a relatively expensive mode of service)? Have children been dumped without care?
- mainstreaming in the educational system? Do these include educable mentally retarded children formerly served by CMHCs? What about emotionally disturbed and minimal brain injured children?
- increased learning and language disability resources? Have these reduced the need for CMHCs to provide services resulting from these difficulties?
- caseload shifts from CMHCs to other providers? At this time it is not apparent that these effects have been documented in any systematic way.

The large number of providers of MHMR services and the complexity of the systems involved make it important that the Mental Health Research Project obtain a broad range of input on the causes and results of the caseload shift from children and youth. We, therefore, solicit input from readers on the extent to which other agencies have experienced this shift, and informed comments or even speculations on the dynamics which may be involved. The project will follow-up on reader input to the extent possible and will summarize and/or publish this input as appropriate.

TABLE 2

Children and Youth Receiving Mental Retardation
Services from CMHCs in Texas

FY	Children (Ages 0-12)	Youth (Ages 13-20)	Total All Clients	Percentage of all MR Clients who are Children & Youth
1973	3,329	2,453	7,727	74.8
1974	3,293	2,539	8,396	69.5
1975	3,116	2,507	8,582	65.5
1976	3,256	2,390	9,015	62.6
1977	3,182	2,397	9,730	57.9
1978	2,733	2,276	9,509	52.7

AN OVERVIEW:

TDMHMR SERVICES TO CHILDREN

by Ernest Fuentes

The Texas Department of Mental Health and Mental Retardation (TDMHMR) was created by the Mental Health and Mental Retardation Act of 1965, House Bill 3 of the 59th Texas State Legislature. The agency was charged with the responsibility of conserving and restoring the mental health of all the State's citizens and to help the mentally retarded develop to their best attainable potential. TDMHMR currently administers eight state hospitals, thirteen state schools and outreach programs, four state centers for human development, a research center, 30 community centers and other facilities. Throughout the entire system, emphasis is given to the provision of quality services for children. In the areas of Mental Health Services, Mental Retardation Services and Community Services, specific programs have been developed to meet the unique needs of children.

In Mental Health Services, TDMHMR administers eight state hospitals. These hospitals operate on a twenty-four hour basis to provide inpatient and outpatient care and treatment to mentally ill and emotionally disturbed individuals. During fiscal year 1978, the state hospitals served 10 children ages 0-5. All state hospitals operate outreach centers in the surrounding communities to assist with outpatient clients. The major emphasis of outreach centers is on mental health education, and mental illness and mental retardation prevention. In FY 1978, the outreach centers served 380 children, ages 0-5.

The Mental Retardation Services Division administers twelve state schools for the mentally retarded. These schools provide twenty-four hour care and treatment for mentally retarded persons of all ages. Most schools have outreach programs for their surrounding rural areas. These programs provide both training and evaluation for the severely retarded, and training and evaluation for those who may have problems upon entering public school. Frequently, the outreach operation is involved in day care services for retarded children under 6. In FY 1978, 109 children, ages 0-5, were served in the state schools, and 665 children, ages 0-5, were served in the outreach programs.

In Texas there are now thirty community mental health and mental retardation centers. These centers are administered by local boards of trustees appointed by counties, cities, hospital or school districts, or a combination of these governments. Each center

develops its programs in response to needs of local citizens; therefore, a variety of services are offered from one center to another. The following is a list of some of the services that the community centers offer children:

- Diagnostic and evaluation services
- For children 0-3, infant assessment and parent training
- Preschool training and education for mentally retarded, emotionally disturbed, disadvantaged and developmentally disabled children
- Child abuse emergency services
- 24-hour crises care

In FY 1978, the community centers served 3,734 children, ages 0-5.

The other TDMHMR facilities, such as Texas Research Institute of Mental Sciences (TRIMS - Houston) and the four State Centers for Human Development (Amarillo, Beaumont, El Paso and Laredo) offer specialized and unique services for children.

The department has interagency agreements with several other state agencies in order to provide comprehensive service delivery. Through coordination and cooperation with other agencies and existing programs, TDMHMR will continue working to provide services for the children of Texas.

Ernest Fuentes, MSSW, is with the Office of Planning and Resource Development at TDMHMR.

ERRATTUM:

The summer issue of the *MHRP Newsletter* (pg. 5) omitted the following from the listing of Health Systems Agencies:

Permian Basin Health Systems Agency
Harley Reeves, Ex. Director
P.O. Box 6391
Midland, Texas 79701
(915) 563-1061

Our apologies for this omission.

MEXICAN AMERICAN CHILDREN: THE FORGOTTEN ONES

by Bernadette A. Bous

*"Children are our most
valuable natural resource."*

Herbert Hoover

Do the health and mental health policies and programs of the national and Texas governments and agencies address the needs of the country's children, specifically Mexican American children? The inventory which follows presents the status of available health and mental health data on Mexican American children. Mental health evaluations and status of children are linked closely to their general health because of the relationship of nutrition to mental health. Also, traditionally it is within the nationwide health surveys that most of the mental health data have been collected. For these reasons, this inventory will address health and mental health data.

Today at the Federal Level

Numbers are the name of the game at the federal level. They are an important variable used to help demonstrate need, establish priorities, form policy and program content, and determine levels of funding. However, numbers for Mexican American children are missing at the federal level. In fact, health and mental health data on Mexican American children are virtually non-existent.

The National Institute of Mental Health

At the National Institute of Mental Health (NIMH), the Center for the Study of Children and the Family conducts research; it collects no demographic data or vital statistics. Occasionally special studies are conducted; to date, two

such studies have contained some Hispanic data, but the data were not directly related to children's mental health. NIMH's Biometry Division reports data on services to children by age, diagnosis and facility, but not by ethnicity. This is despite the fact that some data by ethnicity is available to NIMH from Community Mental Health Centers which forward their center client population data (by age and ethnicity) to NIMH.

The Public Health Service

The Public Health Service of the U.S. Department of Health, Education and Welfare houses the National Center for Health Statistics (NCHS), which is the only federal agency established specifically to collect and disseminate data on health in the U.S. There are three divisions in NCHS which are specifically involved with the regular collection of health statistics. The Division of Health Examination Statistics began in 1960 to administer a series of systematic, nationwide health examination surveys. To date, no data on ethnicity has been collected. At this time, NCHS is compiling a Hispanic supplement which will be initiated in 1981, with the initial dissemination of data scheduled to begin in October, 1982.

The Division of Health Interview Statistics (DHIS) was established in 1957. In 1976, it began to collect health and demographic data related to illness, injuries, disability and health cost, and included an ethnic enumeration. At this time, however, the only data on Mexican American children that has been published by DHIS appeared in two tables in *Advancedata* No. 27, April, 1978. These data were on the number of days hospitalized and number of days disabled.

The third division, Vital Statistics, recommends to the states the form in which birth and death data are collected. However, the

actual collection and determination of format is a state function. Every ten years, the "standard certificate" is revised at the federal level and sent to the states who may or may not adapt the form. The last federal revision was made in January, 1978, and at that time, ethnicity was not included in the form. However, because of recent changes in policy, Vital Statistics has recommended that ethnic data be collected. To date, seventeen states collect ethnic data on births, and eighteen states collect ethnic data on deaths. In the mid 1980s, Vital Statistics will publish ethnic data as a supplement to the Monthly Vital Statistics.

Hispanic Initiatives (Health/ Mental Health)

The Joint Commission on Mental Health of Children transmitted its report to Congress on June 30, 1969 as mandated in Section 231(a) of the Social Security Amendments of 1965 and 1968 (PL 89-97). The mental health needs and problems of Mexican American children were noted in the report. Yet in the ten years since the report was submitted, little action has been taken to resolve the problems noted in the report.

In July, 1977, the Department of Health, Education and Welfare began to take steps to address the needs of Hispanics. Beginning in September, 1978, the needs of Hispanics were brought forward at sixteen HEW-conducted meetings held around the country. Health, but not mental health, was the area of greatest concern voiced by the participants at the town meetings. As a result of these meetings, DHEW adopted the following policy:

- expand provision of primary health care to migrant and seasonal workers and their families;

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- identify migrant worker areas with high infant mortality rates in order to expand maternity and newborn care programs;
- conduct technical assistance sessions with grantees who would serve Hispanic populations;
- increase alcoholism programs for Hispanics; and
- require Medicare contractors to provide bilingual assistance in areas of Hispanic concentration.

To further the collection of data on the country's Hispanic population, in 1979 Congress passed a Joint Resolution, PL 94-311 *Relating to the publication of economic and social statistics for Americans of Spanish Origin or descent*, which directs all major departments and offices of the federal government to collect and publish Hispanic data. Furthermore, the Bureau of the Census must use Spanish language questionnaires, bilingual enumerators and other methods to give full recognition to the needs and concerns of the Spanish origin population. However, it will be several years before these initiatives begin to bear fruit, since preliminary 1980 census reports will not be available until 1982.

The State Environment

What are we doing in Texas to safeguard the interests of and provide for Mexican American children's mental health? That is a difficult question to answer with statistics and numbers, because Texas does not systematically collect data on Mexican American children. The State's social policy system, in large part, depends upon numbers as at the federal level. Questions such as, how many children were located, what age, etc., are used for establishing policy. Since there are no specific data for Mexican American children, a review of the state policy for all children will give us an indication

about the situation for Mexican American children and mental health programs.

Texas did not have a publicly support psychiatric inpatient program for children until 1964. Though the TDMHMR issued a policy in 1970 supporting children services, little seems to have been done. The Governor of Texas called a special Task Force on Children's Mental Health in 1974, but again, no specific programs or policies for Mexican American children resulted.

Since census data indicate that a significant number of Texas' poor families are Mexican American, looking at the situation for poorer children in Texas will shed some light on the existing condition for Mexican American children.

Poorer children in Texas face a bleak prospect. Texas is one of the richer states, yet a poor child has less of a chance of receiving public social services in Texas than in any other state. Texas has the lowest reported rate of children receiving state and local public welfare services. In 1976, Alabama and Georgia, two of the poorest states in the U.S., spent more money than Texas for children's services. Texas spends 37% less than the national per capita average for public welfare. The article, *Where are the Children Going?* in this issue, provides interesting data concerning the number of children being served in the State's Community Mental Health Centers.

The Early Childhood Development Division of the Texas Department of Community Affairs commissioned the establishment of Family and Child Statistics (FACS) in 1973. FACS utilizes data banks from other agencies to provide information about children; however, virtually none of the FACS data is collected by ethnicity.

The Texas Department of Health collects data on health, but the only information that has consistently been collected by

ethnicity are births to "unmarried women" (until this year listed as illegitimate births). At this time, Texas still does not collect ethnic data on vital statistics, births and deaths.

Two highly regarded source books on the condition of children in Texas and the State's policy response to children prepared by the Office of Early Childhood Development are, *The darker side of childhood* and *Still the darker side of childhood*. However, neither of these publications specifically present data on Mexican American children. They are useful sources for data on poor children, from which some extrapolation about Mexican American children is possible.

The Children's Yellow Pages: A guide to statewide services for children and youth in Texas does not list or describe a single health or mental health service for Spanish-speaking children. If there are any health service programs that have a Hispanic bilingual/bicultural component, they are not noted.

Conclusion

According to Beverly Sutton, M.D., director of the Children's Psychiatric Unit of the Austin State Hospital:

"There are no gaps in services to children. There are chasms. What we have are little islands of service."

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This is the condition for all children; for Mexican American children it is so much worse. Mexican American children are one of the single greatest, most rapidly increasing resources for the future of Texas and the nation. There is a crying need for data on Mexican American children so that their mental health needs and care can begin to be addressed at the state and federal levels.

Ed. Note: Sources noted in this article are cited in the bibliography on page 11.

SELECTED BIBLIOGRAPHY ON MEXICAN AMERICAN CHILDREN AND MENTAL HEALTH

There is very little research that has been focused directly on Mexican American children and mental health. Inquiries in this area are often referred to work done on minority children, generally and specifically, and low income children. While much of this work is valuable and interesting, it does not fill the need of gathering and studying data on Mexican American children. The following bibliography represents a sampling of sources that provide information about Mexican American children or children's mental health, particularly in Texas. Readers are encouraged to provide the *MHRP Newsletter* with additional sources they have found useful.

- Bernal, Ernest M., Jr. Adapting assessment procedures to specific population characteristics: The Chicano child. Paper presented at the Annual Convention of the American Psychological Association, San Francisco, August 1977.
- Birch, H.; & Gussow, G.D. *Disadvantaged children*. New York: Grune & Stratton, 1970.
- Bronfenbrenner, U. Socialization and social class through time and space. In E. Maccoby, T. Newcomb, & E. Hartley (Eds.), *Readings in social psychology*. New York: Henry Holt, 1958.
- Casas, J. Manuel & Keefe, Susan E. (Eds.). *Family and mental health in the Mexican American community*. Monograph No. 7. Los Angeles: Spanish Speaking Mental Health Research Center, 1978.
- Clarke-Stewart, A. *Child care in the family*. New York: Academic Press, 1977.
- Comer, James P. & Poussaint, Alvin F. *Black child care: How to bring up a healthy Black child in America -- A guide to emotional and psychological development*. New York: Simon & Schuster, 1975.
- DeBlasse, Richard R. *Counseling with Mexican American youth: Preconceptions and processes*. Austin: Learning Concepts, 1976.
- Florez, John. Issues and problems affecting Hispanic youth: An analysis and a blueprint for action. In Miguel Montiel (Ed.), *Hispanic families: Critical issues for policy and programs in human services*. Washington, D.C.: National Coalition of Hispanic Mental Health and Human Service Organizations, 1978.
- Grebler, L.; Moore, J.W.; & Guzman, R. *The Mexican American people*. New York: Free Press, 1970.
- Green, J.M.; Trankina, F.J.; & Chavez, N. Therapeutic intervention with Mexican American children. *Psychiatric Annals*, 1976, 6(5), 60-75.
- HR 4962. Child Health Assessment Act of 1979. (not passed)
- Keefe, S.; Padilla, A.; & Carlos, M. Emotional support systems in two cultures: A comparison of Mexican Americans and Anglo Americans. Los Angeles, California: Spanish Speaking Mental Health Research Center, 1978.
- Keniston, K.; & The Carnegie Council on Children. *All our children*. New York: Harcourt Brace Jovanovich, 1977.
- Keniston, Kenneth. *All our children: The American family under pressure*. The Carnegie Council on Children. New York: Harcourt Brace Jovanovich, 1977.
- Langham, Barbara. *The darker side of childhood*. Early Childhood Development Division, Texas Department of Community Affairs. Austin, Texas, 1974.
- Langham, Barbara. *Still the darker side of childhood*. Early Childhood Development Division, Texas Department of Community Affairs. Austin, Texas, 1978.
- Laosa, L. Maternal teaching strategies and field dependent - independent cognitive styles in Chicano families (ETS RB 77-9). Princeton, New Jersey: Educational Testing Service, 1978.

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- Martinez, Joe L. (Ed.) *Chicano Psychology*. New York: Academic Press, 1977.
- McClintock, Charles G. Development of social motives in Anglo-American and Mexican American children. (In C.A. Hernández; M.J. Haug; & N.N. Wagner (Eds.), *Chicanos: Social and psychological perspectives* (2nd ed.). St. Louis: The C.V. Mosby Co., 1976.)
- Ogbu, J. *Minority education and caste*. New York: Academic Press, 1978.
- Padilla, Amado M. & Ruiz, René A. *Latino mental health: A review of literature*. Washington, D.C.: U.S. Government Printing Office, 1973. (1976 reprint, DHEW Publication No. (ADM) 76-113).
- Padilla, Eligio R.; Padilla, Amado M.; Ramirez, Robert; Morales, Armando; & Olmedo, Estaban L. Inhalant, marijuana and alcohol abuse among barrio children and adolescents. Occasional Paper No. 4. Los Angeles: Spanish Speaking Mental Health Research Center, 1977.
- PL 94 311. 94th Congress Jt. Resolution. Relating to the publication of economic and social statistics for Americans of Spanish Origin or descent.
- Profiles of children. White House Conference on Children and Youth. Washington, D.C.: GPO, 1970.
- Ramirez, Manuel III & Castañeda, Alberto. *Cultural democracy, bicultural development and education*. New York: Academic Press, 1974.
- Report of the Joint Commission on Mental Health for Children. *Crisis in child mental health: Challenge for the 1970s*. New York: Harper and Row, 1970. WS 350 J742C, 1970.
- Report of the Task Panel on Mental Health and American Families: Sub-Task Panel on Infants, Children, and Adolescents. *Reports submitted to the President's Commission on Mental Health*, Vol. III. Washington, D.C.: U.S. Government Printing Office, 1978. (Stock No. 040-000-00392-4).
- Romero, A. *The Mexican American child: A sociological approach to research*. Los Angeles, California: Spanish Speaking Mental Health Research Center, 1978.
- S 1204; s Rept. 96-274. Child Health Assessment Act of 1974. (not passed)
- Sutherland, & Moore, B.; *Our youngest children*. Austin, Texas, 1971.
- Tjossem, T. (Ed.) *Intervention strategies for high risk infants and young children*. Baltimore University: Park Press, 1976.
- Zlotkovich, C.P.; Wright, R.; & Moore, R. *Texas Fact Book*. Bureau of Business Research. The University of Texas at Austin. Austin, Texas, 1978.



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WINTER 1980

Government Reorganization Evaluation:

Overlooking the Mental Health Needs of Mexican Americans

by Bernadette A. Brusco

Growth in state government spending and of agencies that deliver human services has historically been of concern to state legislatures who must account for tax dollar expenditures. In response to this concern, governmental evaluation and reorganization studies are often mandated in order to address issues of cost effectiveness, bureaucratic efficiency and programmatic evaluation. The first federal effort in evaluative reorganization occurred in 1911, with subsequent efforts in 1949 and 1953. States began to commission these studies in 1917 and must do so on a regular basis.

Texas, however, has not actively or continually engaged in any evaluation/reorganization effort. In 1931, the Forty-second Legislature commissioned the first such study which resulted in several organizational and operational changes. A second study was undertaken in 1972, but all recommendations were rejected by the voters. In 1973, through a legislative order, the State implemented a system of program budgeting and evaluation known as zero-based budgeting. This system has served to assure cost effectiveness and provide some organizational control on the State's programs.

Hobby-Clayton Committee

In 1976, the Sixty-fourth Legislature established the Joint Advisory Committee on Government Operations through Senate Bill 319. This committee was chaired by Lt. Governor W. P. Hobby, and Speaker Bill Clayton served as vice-chair. The committee became known as the Hobby-Clayton Committee and was charged with the following responsibilities:

- develop proposals to increase the effectiveness of delivery of services to the citizens of the State
- provide for the improvement of the structure and administration of state government to assure the delivery of governmental services at the lowest possible cost

- recommend policies and programs to minimize creation of new departments and agencies of state government and to control the growth of existing departments and agencies
- propose recommendations for the elimination of government programs and services that duplicate or exceed in costs those services offered by private business

The 18-member committee was comprised of the Lt. Governor, Speaker of the House, Secretary of State, three senators, three representatives, and nine citizens appointed by the Governor. This committee studied five areas of government:

- Health and Welfare (which included TDMHMR and Community Mental Health Mental Retardation Centers - CMHMRCs)
- Education
- Natural Resources
- Management Review and Policy Direction
- Administration and Fiscal Management

Subcommittees were established which addressed the following questions as each program was examined:

1. What is the need for this program or service?
2. Can the effectiveness or efficiency in the delivery of these services be improved?
3. Are there instances where similar services are being provided in more than one agency to respond to similar needs, problems, or target groups?
4. Can these services be provided at a lower cost without inhibiting their effectiveness?
5. Can this service or improved services be provided at less cost or more effectively through modification of the existing delivery system or within another organizational framework?

Data were provided to the committee by agencies, private groups and citizens through surveys, questionnaires, hearings, site visits and submission of information exhibits. After 13 months, the committee prepared a final report which contained 113 recommendations.

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The recommendations directed toward CMHMRCs were:

1. Patients admitted to state hospitals should be screened by a CMHMRC or an outpatient department of a state hospital.
2. A system of joint discharge planning should be established between a state hospital and CMHMRC.
3. The appropriation pattern for grant-in-aid funds for CMHMRCs should be changed from a lump sum to the following programmatic areas:

- Center administration
- Screening and referral services
- Outpatient services
- Special education classes
- Alternative residential care and 24-hour residential care
- Sheltered work training-day/evening care

Recommendation 3 was adopted, and recommendations 1 and 2 were implemented on a more or less informal basis.

Senate Bill 67 Committee

In the past two and a half years, the concern about government efficiency has continued. In 1979, the Sixty-fifth Legislature created a Special Committee on Delivery of Human Services in Texas, Senate Bill 67. The responsibility of this committee is to examine the delivery and growth of human services required by federal and state laws. A thorough study is being conducted of existing human services provided by state-supported entities and the private sector; the populations served by these services; the effective use of state funds; and relevant federal and state laws. The committee is composed of four members of the Senate and eight private citizens appointed by the Lieutenant Governor. They are:

Helen Farabee
Chair

Senator Chet Brooks
Vice-Chair

Morris Atlas
Rebecca Canning
Joaquin G. Cigarroa, Jr., M.D.
John E. Codwell, Ph.D.
Frank C. Erwin, Jr.
Senator Bill Meier
Ann Richards
Senator A. R. Schwartz
Max Sherman
Senator W. E. (Pete) Snelson

Dr. June Heyer is executive director.

The first subcommittees to be established were in the following areas:

- 0-17 Age Group
- 18-64 Age Group
- 65-Over Age Group

They are following the same procedures used by the Hobby-Clayton Committee to collect information. During April and May, 1979, public hearings were held, and as a result of these hearings, the committee met with staff from the Offices of the Governor and Lieutenant Governor in September, 1979, and decided on a new direction. Initially, the committee was not going to deal with services on an agency-by-agency approach. However, TDMHMR has been selected as an agency to be examined specifically for delivery of services. This study of TDMHMR will be conducted by the committee, the Governor's Office and the Texas Research League. The areas/issues to be studied are:

1. Operational aspects of personnel operations and the development of appropriate procedures
2. Data processing operations
3. TDMHMR's request of the Texas Research League to devise and implement managerial and operational mechanisms
4. Policy and structure as it affects policy and duplication of services (this will come under the committee's review)

A subcommittee on mental health and mental retardation issues has been composed of the chairs of the three age group subcommittees. These subcommittees will meet through September, 1980, when the final report is due.

In reviewing the minutes of the committee and background reports submitted by committee staff, it is difficult to determine the focus of the study. Government operations are being broadly interpreted. Every aspect of TDMHMR is being examined with attention focused on the organization of the central

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The NEWSLETTER OF THE MENTAL HEALTH RESEARCH PROJECT serves as a vehicle for communication with professionals, laypersons and the general public concerning issues related to mental health and mental retardation. Persons interested in publishing articles contained herein should contact the editor.

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office, community mental health and mental retardation centers, state hospitals for the mentally ill, state schools for the mentally retarded, and laws affecting mental health and mental retardation. Special attention is being given to the Community Services Division of TDMHMR (which works closely with the CMHMRCs) and community centers. Committee concern seems to be focused on:

1. Delivery and accountability of services of CMHMRCs
2. Relationship and cooperative working arrangements between CMHMRCs and state institutions
3. Effectiveness of services that CMHMRCs deliver
4. Accounting system of CMHMRCs
5. What monies the State is contributing to CMHMRCs and for what purposes those monies are being used

Service Delivery Implications for Mexican Americans

Special committees of the type described above are an integral and powerful part of Texas policymaking. These committees operate at taxpayer expense and are put forth as experts who represent citizens' interests. Their recommendations are presented to the State Legislature for consideration and often become state law or policy. However, it must be asked: Whom do they represent and with whose interest are they concerned?

Several things are clear. Minorities are either not represented or very under-represented on most special committees, and on these two special committees, in particular. The first committee had no Mexican American members; the second, only one. Providing appropriate mental health services to Mexican Americans was never an issue for the first committee and is not at this time emerging as an issue for the second. This is documented by a careful reading of all minutes, staff reports, submissions and final reports. In all the rhetoric about government efficiency and the effectiveness of programs and duplication of services, there is no attention given to the mental health needs of approximately 20% of the State's population which is Mexican American. Indeed, even for those regions of Texas where Mexican Americans comprise 80% of the population, the issue of providing appropriate mental health services to Mexican Americans does not arise. There appears to be no acceptance, let alone acknowledgement, by these Texas committees that the State's Mexican Americans have mental health needs that must be addressed with culturally sensitive, appropriate services. Mexican Americans are seldom acknowledged as a special or target group in the evaluation of mental health services. The "efficiency" and "cost effectiveness" measures used by these government committees are not always relevant to

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culturally specific services, and, in many cases, work against those few services that may be provided.

The existence in Texas of the Mexican American population is undisputed; Mexican American's mental health needs have been established by experts in the mental health field. The appropriateness and utility of culturally specific services have been demonstrated by experts in the mental health area. One wonders why committees of the state government, composed of supposed experts and citizens charged with evaluating human service systems, do not deal with this significant issue. The conclusions can only be that these committees are not representative of the interests of Mexican Americans. Furthermore, the mental health interests and needs of Mexican Americans in Texas are not being considered, let alone protected, in the policymaking process of government agency reorganization and evaluation.

Centers for Human Development and Community Mental Health Mental Retardation Centers: *What's the difference?*

by David G. Ramirez

At present, the citizens of Texas are served by 29 Community Mental Health Mental Retardation Centers (CMHMRCs) and 4 Centers for Human Development (CHDs). The difference between these two forms of organizational entities is far from clear. As such, this article will only begin to address the issue of differences between CMHMRCs and CHDs. Nevertheless, the mental health consumers in Texas must become attuned to the differences, particularly those community groups which have identified a need for additional mental health/mental retardation services in their communities, and which are considering the establishment of a CMHMRC or CHD in their area.

The CMHMRCs operate under the federal authority of Public Law 94-63 and the authority of House Bill 3 in Texas. Public Law 94-63 maintained a number of guidelines which are of particular interest herein:

- that the CMHMRCs would maintain twelve essential services which include:
 - inpatient, outpatient, day care and other partial hospitalization services and emergency services
 - specialized services for the mental health of children and the elderly, including a full range of diagnostic, treatment, liaison and follow-up services

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The Mexican American Male: A Brief Review of the Literature

by Ramiro Valdez, Ph.D.

The growing interest in the family over the past several years has resulted in an upsurge of family studies in the social sciences. The behavioral sciences, as one of the sister professions under the broad rubric of social studies, have coupled the family studies movement with a movement of their own: transcultural psychiatry. This joining of the two has produced more and more studies on ethnic families in the scholarly literature. Family studies in general are significant to the behavioral sciences because a clearer understanding of healthy functional families could result in a better understanding of a dysfunctional family, and, therefore, enhance therapy. Studies among ethnic families are important because of the fact that acculturation processes often produce added stress in family functions; because ethnic families, as "outsiders" of the mainstream, are often subject to social sanctions that can lead to a disruption of routine family procedures; and because of an increasing effort towards pluralism in the behavioral sciences so that each ethnic group can be given acceptable consideration and help when they encounter disruptive problems. Thus, an understanding of normal and healthy rituals and routines among ethnic families, which may differ from those of mainstream families, is a prerequisite to effective therapeutic efforts on their behalf.

Mexican American family studies have been about as frequent as those of any other ethnic group (a brief summary of these can be found in Salinas & Flores, 1977); however, there is one small difference. Mexican American family studies often focus on the roles of males and females as sex agents within the family (e.g., Ginsberg, McGuinn, & Harburg, 1970; Jones, 1948; Pearson, 1964; Peñalosa, 1968; Staples, 1971). Regrettably, the depictions of the Mexican American male in much of the literature would be more of a hindrance than a help in therapeutic efforts. This is due to the portrayal of the male as insecure, exaggerating his masculinity, and relishing the physical conquest of other men and the sexual conquest of women. It has been the experience of the author, after many years of living in Mexican American neighborhoods and doing clinical work with Mexican American families, that this is a grossly exaggerated misrepresentation. Those men that fit this description, and they do exist among Mexican Americans just as they do in all ethnic groups, are the exception rather than the norm. While there is general agreement among Mexican Americans as to the exaggeration of the descriptions in the literature,

perhaps it has not been stressed enough that the mode of observation may have an effect on the observations made.

Observation is basic to the scientific method. It is usually the practice of orthodox scientists to detail their methods of observation under a methodology or techniques section of their work; often this section comprises the major portion of the presentation. While there may have been some speculation as to the effect of the methods on the outcome, there has yet to be a major published study correlating the two. This would be especially helpful in the study of ethnic families so that clinicians and practitioners could be more informed as to the validity of the generalizations made in the literature. Consequently, they could conceivably be more effective in treating ethnic families.

For example, during the 1950s, the primary methods of observation utilized by the social scientists to study ethnic families in America were the ones used by anthropologists. Such techniques as participant observation and key informant were utilized frequently (e.g., Díaz-Guerrero, 1955; Fernández-Marina, et al., 1958; Ramírez & Parres, 1957; Jaco, 1959). However, even more frequently utilized was the traditional review of the literature. While it is always necessary to review the literature, it is important to recall that this may often be a mere "mopping up" procedure (Kuhn, 1973). This is particularly important when the "wrong" literature is reviewed. For example, Woods (1949 and 1956) applied the writings of Oscar Lewis and Robert Redfield to her studies of Mexican Americans, totally oblivious of the fact that these two authors made observations of people in isolated, small Mexican villages: quite a different group from Mexican Americans. Overemphasis on literature reviews could be misleading.

The anthropological techniques of the 1950s, coupled with an emphasis on the literature, resulted in a view of the Mexican American male that would be more of a hindrance than a help to a therapist. This is not because anthropological techniques are faulty, but because they may have been used to substantiate pre-existing views. The consequences of this are that, to this very day, Mexican Americans are trying to combat the effects of this literature on the views of therapists.

The decade of the 1960s, a time of ethnic pride and identity in this country, brought only minimal changes in the descriptions of the Mexican American male and his role in the family. The exaggerated masculinity and insecurity previously generalized to this group continued (e.g. Peñalosa, 1968; Madsen, 1964; Rubel, 1965; Galvin & Ludwig, 1961; Kline, 1969). Despite the very real possibility that the Mexican American male roles may have changed during this decade, there is little indication of this in the literature.

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Perhaps a reason for this is the sociological approach to the study of ethnic families during the 1960s. Octavio Romano (1973) has pointed out the weakness of the approach of most sociologists and psychologists by indicating that often their observations are mere substantiations of their pre-determined views. As in the 1950s, this pseudo-inductive method predominated.

The 1970s have, regrettably, continued with much of the same descriptions of the Mexican American male as the two previous decades. While there has been some effort to refine techniques and describe the mode of observation in more detail (e.g., Simmons, 1974) the descriptions have continued virtually unchanged. Particularly disturbing are those studies that rely most on the existing literature (e.g., Duran & Bernard, 1973; Gómez, 1972; Haddox, 1970; Kuenster, 1972; Grebler, Moore, & Guzmán, 1970; Heller, 1971). In other words, it is possible that a study originally conducted in Mexico to support predominating beliefs could have been cited in the 1960s and again in the 1970s to the extent that a myth prevails in the literature that may have never existed empirically in this country. This is particularly disturbing when the male image is applied to clinical issues (e.g., Torrey, 1972 and Wagner & Haug, 1971). The effect of this could be that therapy could not only be futile, but even detrimental.

There is an indication of a change in the years to come, however. Within the past few months, Cromwell & Ruiz (1979), Mirandé (1979) and Ramírez (1979) have all questioned the male role in the Mexican American family and the clinical implications of this role. Perhaps the decade of the 1980s, already being called the decade of the Hispanic, will result in a more

realistic description in the scientific literature of the Mexican American male.

Finally, it should be recalled by those who would do studies of ethnic families for the purpose of enhancing therapeutic efforts that the inductive method may not transcend cultural barriers and remain intact. It is possible that one's pre-determined views of a group will be substantiated by our observations, for it has already been established that reality is socially determined (especially in Berger & Luckman, 1966). Care and consideration should be taken to describe ethnic families as they are, rather than as we may think they are.

Ed. Note: A detailed list of sources cited in this article is available upon request.



Dr. Valdez joined the MHRP staff in January of this year, coming to us from Brandeis University where he obtained a Ph.D. in social welfare policy with a specialty in research. Originally from San Antonio, he is a graduate of Our Lady of the Lake University and Burbank High School. Hobbies include marathoning and classical music. Welcome to our staff, Ramiro!

MHRP Notes

The National Advisory Committee of IDRA's Mental Health Research Project held its first meetings on November 9, 1979 and November 16, 1979. To accommodate the schedules of the six-member committee, three members attended each session. Attending the meetings were Dr. Amado Padilla, Dr. Carlos Arce, Dr. Carmen Carrillo, Dr. Floyd Martínez, Ernesto Suazo, and Dr. Marta Sotomayor. The MHRP established the committee to insure that the process and outcomes of its research will have maximum generalizability to the mental health needs of Mexican Americans throughout the country. As such, these six nationally recognized leaders in the area of mental health will meet annually with project staff to discuss, from a national perspective, the critical issues in improving the delivery of mental health services to Mexican Americans.

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The proceedings of the conference held in San Antonio, "Mental Health and Mexican Americans: Planning for the 80s," are available at cost from IDRA's MHRP. This 228-page document contains the general session presentations along with summaries of the issues and recommendations discussed in the conference workshops. These proceedings represent the views and recommendations of the participants on improving the delivery of mental health services for Mexican Americans in Texas. Requests for copies should be made to:

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CHDs & CMHMRCs

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- consultation and education services for individuals and entities involved with mental health services
- screening services
- follow-up care for residents discharged from a mental health facility
- transitional halfway house services
- prevention, treatment and rehabilitation for alcoholism, drug addiction and abuse
- governance of the centers would be maintained by a local board of trustees
- funds for the operation of the center would be secured from state grant-in-aid allocations, federal monies, local and other forms of support

The diversified funding base makes the centers accountable to federal, state, and local entities; thus, their services must comply with the guidelines of each of these sources of support. The CMHMRCs were intended to offer an alternative to institutional placement and to expand preventative efforts in the areas of mental health, mental retardation, drug abuse and alcoholism. According to Texas Department of Mental Health and Mental Retardation figures, these 29 CMHMRCs served 105,719 clients in Texas in 1979.

The Centers for Human Development (one each in Amarillo, Beaumont, El Paso and Laredo) operate under the authority of House Bill 686, and, according to TDMHMR documents, are defined as follows:

A TDMHMR facility established to provide to mentally retarded persons such services as *diagnosis and evaluation, counseling, day care, training, respite care*, etc. Also, short-term *domiciliary services* are available for both mentally retarded persons and mentally ill persons so as to provide a community alternative to institutional placement.

The emphasis of these centers appears to be on providing services for mentally retarded persons. The centers are funded by the State, and as such need only comply to state guidelines for service provision. The CHDs are total entities of the State. Executive directors are appointed by the Board of Trustees of TDMHMR. All staff are state employees. There are no community boards of trustees or advisory councils.

Three primary areas of differences emerge even in this crude analysis: 1) the funding basis and hence accountability structures appear substantially different; 2) the services provided appear different (at least as defined by the goals of the entities), with CMHMRCs providing a broader range of services and CHDs placing a greater emphasis on mental retardation; and 3) the governance patterns appear to be different, with CHDs not required to have

community board input while CMHMRCs are governed by a local board. IDRA's Mental Health Research Project will continue to research the differences between these two organizational forms to gather information on which type of service delivery system is most appropriate and responsive to the mental health needs of Mexican Americans.

The Advisory Committee on CMHMRCs: Is the Committee Representative?

by Bernadette A. Brusco

At its July 8, 1978 meeting, the Board of Trustees of the TDMHMR was presented with a recommendation that a Community Mental Health Mental Retardation Center (CMHMRC) Advisory Committee be created. This recommendation was brought by the Texas Council, which is a voluntary association of the Boards of Trustees of CMHMRCs. Two advisory committees to the Commissioner of TDMHMR had already been established: a medical committee and one representing mental health. Like these two, the CMHMRC Committee would report to the TDMHMR Commissioner. After eight months of consideration, the Board of TDMHMR approved establishment of the CMHMRC Advisory Committee at its February 23, 1979 meeting.

Organization and Purpose

The purpose of the committee is to advise the Commissioner on the following issues:

- 1) administration of basic services provided by the CMHMRCs
- 2) uniform business procedures for CMHMRCs
- 3) construction for CMHMRCs
- 4) proposed legislation on "Rules of the Commissioner" pertaining to screening and aftercare

Members of the committee are appointed by the Commissioner, who along with the Deputy Commissioner, serves as an ex-officio member. Each chairperson of a CMHMRC may submit one name for nomination. Also, nominations may be solicited from CMHMRC sponsoring agencies, Health System Agencies, state advocate associations, or other interested parties. Members of the committee may be currently serving as trustees of CMHMR centers or be former trustees. The committee "shall reflect social, economic and minority groups, as well as the State's geographical areas." The President of the Texas Council is a member.

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The committee serves at the pleasure of the Commissioner for one year, and members may be reappointed to the committee. Meeting times and tasks are determined by the Commissioner, within the committee's stated purpose. Members are not compensated for their services; however, travel costs are paid by TDMHMR. A chairperson and vice-chairperson are elected by members.

When this committee was originally proposed, it was to be made up of nine members. Before its final adoption, the membership was increased to eleven and the ex-officio members were added. Also, the nominating procedures were expanded to permit nominations to be submitted by "other interested parties." It was hoped that this expansion and the opening up of nominating procedures would insure "broader consideration for geographic representation...including urban and rural areas." The first committee has been appointed and it does not appear to fulfill the mandate.

Non-Representativeness

The first committee was appointed in September, 1979. The roster of members is presented below. Members are chosen from all the geographic regions of the State. However, the committee is not representative of the State's minority groups. There are no Mexican American members and only two Blacks. Finally, the committee members are not representative of the State's various social groups in either education or occupation.

At this time it is difficult to evaluate the committee on any criteria other than external criteria because it has met only once. However, on these criteria the committee leaves much to be desired. The committee's composition fails to fulfill its own mandate and the basic notion of equity of representation. The composition of this committee does not reflect adequate sensitivity or commitment on the part of TDMHMR to seek Mexican American input in community mental health services.

(Sources for this article are listed on page 8.)

Advisory Committee on CMHMRC'S to the Commissioner of TDMHMR*

Name and City	CMHMRC Represented	Health Service Area	Current Member of Board of Trustees (Yes-No)	Spanish Surname	Black	Other	Profession or Occupation
Frank M. Adams Beaumont	President Texas Council of CMHMRC's, Inc.	10	Yes			1	Attorney
E. Warren Alexander Hamilton	Central Counties	6	Yes			1	Rancher
Joseph L. Bart, Jr. Houston	Harris County	11	Yes			1	Public Relations Railroad
Ms. Shirley Camfield Fort Worth	Dallas/Fort Worth	5	No			1	Past President State Mental Health Assoc.
Frances Davis, M.D. Amarillo	Amarillo MHMR	1	No			1	Psychiatrist
Mrs. Frank Karaffa Waco	Waco	6	No			1	Past President T.A.R.C.
Menton Murray, Sr. Harlingen	Tropical Texas	8	Yes			1	Attorney
Ira Smith, Jr. San Antonio	Bexar Country	9	Yes		1		Computer Analyst
Nancy C. Speck, Ph.D Nacogdoches	Deep East Texas	10	Yes			1	Special Education
Curtis J. Spier, M.D. El Paso	El Paso MHMR	3	Yes			1	Physician
Theodore Talbot Waco	Heart of Texas	6	Yes		1		Administration

Totals where applicable

0 2 9

*Source: Memo circulated by Community Services TDMHMR - 9/28/79.

Literature Review

by Sharon Sepúlveda Hassell

Hispanic Families: Critical Issues for Policy and Programs in Human Services - Miguel Montiel, ed. (Washington: National Coalition of Hispanic Mental Health and Human Service Organizations, 1978).

The eight articles compiled within the volume edited by Montiel offer the reader a brief, yet comprehensive overview of the prevalent human services policy and programmatic issues related to the delivery of health and mental health services to Hispanics. *Hispanic Families* addresses the commonalities of the health needs and resources of Chicanos, Puerto Ricans and Cuban Americans while maintaining an awareness of the unique characteristics of each population. Several contributors stressed the necessity of recognizing the political, economic, historical and socio-cultural dynamics of the Hispanic experience in the design of human service programs.

Specific populations considered by the authors include families, women, youth, the aged and the indigent. This comprehensive approach highlights the importance of designing policies and programs for specific target populations while recognizing the impact that community and socio-cultural factors have upon intervention strategies. Prevailing beliefs and misconceptions concerning the Hispanics' use and acceptance of human services are examined through presentation of results of previous service efforts and research findings. The inadequacies of former human service policies and programs are noted by several authors who offer numerous alternatives.

The need for Hispanics to develop an action-oriented position by becoming involved in advocacy for acceptable, accessible human services in their community is stressed throughout *Hispanic Families*. Within his editorial remarks, Montiel recommends that the volume be evaluated in terms of its usefulness for offering new insights, ideas, and recommendations regarding human services design and delivery to Hispanics. Judged on that basis, *Hispanic Families* is a worthwhile addition to the existing literature in the field of human services delivery.



Sharon Sepúlveda Hassell joined the IDRA staff as field researcher for the Mental Health Research Project. In 1977, Ms. Hassell received a Master of Science in Social Work from the University of Texas at Austin where she specialized in clinical social work. Both Ms. Hassell's graduate studies and employment experiences have dealt with the delivery of community mental health services. She was employed as a counselor at La Clinica de Consulta Familiar, a bilingual/bicultural treatment center located in Houston, Texas. She subsequently delivered individual, family and group counseling services at the Family Guidance Center in Dallas, Texas. Although Ms. Hassell has worked with a variety of client populations, she is particularly interested in the delivery of services to children and families, and depressed women. She has worked closely with the Dept. of Human Resources in delivering therapeutic services to low-income families and has offered numerous consultations regarding the delivery of bilingual/bicultural services to Mexican Americans. Ms. Hassell is a member of the National Association of Social Workers and was recently admitted to the Academy of Certified Social Workers.

Sources for The Advisory Committee on CMHMRCs: Is the Committee Representative? (pg. 6):

1. TDMHMR Board of Trustees, Minutes of Meetings; Friday, February 23, 1979.
2. TDMHMR Board of Trustees, Minutes of Meetings; Friday, July 13, 1979.
3. TDMHMR Board of Trustees, Minutes of Meetings; Friday, September 21, 1979.
4. Memo, Roster of Members Advisory Committee on CMHMRC's to the Commissioner of the Texas Dept. of MHMR - Community Services, 9/28/79.



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NEWSLETTER OF THE MENTAL
HEALTH RESEARCH PROJECT

VOL. 2 NO. 2

UPDATE SR 67: THE SPECIAL COMMITTEE ON DELIVERY OF HUMAN SERVICES IN TEXAS

by Bernadette A. Brusco

The Special Committee on Delivery of Human Services in Texas, created by Senate Resolution 67 (SR 67), is continuing its study into the organization, functions and responsibilities of the Texas Department of Mental Health Mental Retardation (TDMHMR) and particularly the Community Mental Health Mental Retardation Centers (CMHCs). In the last issue of the *MHRP Newsletter* it was reported that this Senate committee had established broad parameters in the conduct of its inquiry. (See *MHRP Newsletter*, Winter 1980). As was the case with the committee's predecessor — the Hobby-Clayton Committee — issues involving appropriate mental health services for minorities, including Mexican Americans in Texas, have not been addressed; at least there is no record of minority mental health issues being addressed in the official minutes of either committee, or in the final report of the Hobby-Clayton Committee.

MH/MR Subcommittee Recommendations

The committee has been divided into four subcommittees, one of which is addressing mental health/mental retardation issues and the function and organization of TDMHMR. At three separate meetings (February 7, 1980, March 6, 1980 and April 9, 1980), the Subcommittee on Mental Health Mental Retardation Issues (MH/MR Subcommittee) approved 10 recommendations impacting the mentally ill and CMHCs. Briefly, these recommendations are:

1. A uniformed single client information system for institutional and community-based TDMHMR facilities should be developed and implemented.
2. The statute governing state grants-in-aids should be amended to specify that the first priority for use of such funds shall be for screening and community support services for the mentally ill who are in significant risk of placement in a state hospital. Furthermore, TDMHMR should develop guidelines to enforce this policy and may withhold grant-in-aid from CMHCs not complying.

3. The Mental Health Code should be amended to specify that for counties having CMHCs, officers serving warrants for emergency hospitalization shall notify the centers and specify the facility to which the individual was admitted.

4. The Mental Health Code should be amended to specify that a recommended plan for appropriate continuing care must be prepared and delivered to the CMHC that is going to accept responsibility for the patient.

5. TDMHMR, with the advice and assistance of the State Bar, Legislative Council, Senate Human Resources Committee, other appropriate legislative committees and interested groups, should recommend to the 67th legislative committees those changes in the Mental Health Code which are necessary or desirable to protect the constitutional rights of mentally ill persons.

6. The Deputy Commissioner for MH/MR Program Operations shall be responsible for budgetary planning for and supervision of rules, regulations and standards regarding TDMHMR's governance of CMHCs.

7. Centers shall provide screening for persons seeking voluntary commitment and those being involuntarily committed. When these services can be more economically delivered by another facility, the Commissioner may so designate that facility.

8. The need for public emergency psychiatric beds in each community center service area should be presented to the 67th Legislature for funding considerations.

9. Uniform rules governing confidentiality of records of persons served by TDMHMR and CMHCs should be developed.

10. The Legislature should amend statutes to provide that the policy of the state should be to encourage local agencies and private organizations to assume responsibility for effective administration of MH/MR services.

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Note: These recommendations are taken from the MH/MR Subcommittee's official minutes for the three meetings previously noted.

These recommendations cover a wide range of issues and will be incorporated into the MH/MR Subcommittee's final report. This report will be considered by the whole committee and finalized in September 1980.

Three Implications of the Recommendations

Three issues have surfaced in the work of the committee and subcommittee that are of particular importance to Mexican Americans. While a survey of the minutes of the committee and subcommittee indicates that the mental health needs of Mexican Americans have not been addressed, it does indicate that the needs of one special population has been given consideration. At the April 9, 1980, MH/MR Subcommittee meeting, two recommendations were passed regarding autistic citizens. The first requested the 67th Legislature to consider creating a Joint Interim Committee to study the needs of autistic citizens and to present recommendations to the 68th Legislature. The second recommended that TDMHMR study 1) the appropriateness of existing institutional environments and programs for autistic clients, and 2) effective alternatives.

These same recommendations could be adopted by the committee to address the issue of providing appropriate services to Mexican American clients. A joint interim committee on Mexican American mental health needs would be an important vehicle in drawing attention to and providing data in an area that heretofore has not been a point of focus in the Texas mental health and mental retardation system. The data would be invaluable in implementing many of the recommendations approved by the committee, particularly recommendations 4 and 5.

A second issue which surfaced is the reorganization of TDMHMR. At the MH/MR Subcommittee meeting of December 6, 1979, a request was forwarded to TDMHMR for the development of a plan for departmental reorganization on a geographical basis. In addition, this plan was to address the "definition of the specific jurisdiction of community centers and the central office of TDMHMR in terms of designated responsibilities" (Minutes of MH/MR Subcommittee meeting, December 6, 1979).

In response to the committee's request, on January 18, 1980, the Board of Trustees of TDMHMR adopted a "Resolution on Reorganization" which stated that:

1. The department is committed to promoting delivery of services in an economic and efficient manner;
2. A workshop was convened in October 1979 to address these issues;
3. A principal issue at the workshop was to promote coordination between CMHMR centers and other TDMHMR facilities;
4. A principal conclusion reached at the workshop was that the TDMHMR reorganization should be on a regional basis;
5. The best approach to this reorganization would be the adoption of a plan which will provide for reorganization of the central office on a geographical basis; therefore be it, and
6. Resolved, that the board directs the Commissioner to propose such a plan as expeditiously as possible.

This resolution was presented to the MH/MR Subcommittee on February 7, 1980, and was deemed inadequate and not concurrent with the MH/MR Subcommittee's time frame. The MH/MR Subcommittee requested that the committee staff develop an alternative reorganization plan, and present it to the entire committee. At this time, even though the committee staff is working on a reorganization plan, TDMHMR is continuing with its own reorganization plan. The TDMHMR plan was discussed in closed Executive Session, May 2, 1980.

Geographical reorganization may have implications for providing appropriate mental health services to Mexican Americans. Issues such as the potential effect that regional reorganization may have in fostering local regional policy reflective of special population needs, the distribution of resources to rural and border areas, and the permissible regional flexibility allowed in programming are related to Mexican Americans in Texas.

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Finally, a third issue raised has been the possible assumption of local center authority and programming by TDMHMR. This is related to the continuing issues of the amount of responsibility TDMHMR will have over the CMHCs and the level of accountability TDMHMR will require of the CMHCs as a stipulation for CMHCs receiving a grant-in-aid award from TDMHMR. This issue becomes more important as the state's share of the CMHC's budget increases, while the federal and local shares decrease. An increasing number of CMHCs in Texas (it is estimated six out of the thirty by June 1, 1980) will be without any federal support. State elected officials and bureaucrats quite naturally require CMHC accountability when state funds are expended. However, an additional crucial issue is the need to maintain local input and policy setting authority so that regional and local special populations can be appropriately served. At the subcommittee meeting on April 9, 1980, several expert witnesses, including CMHC staff and elected county officials, appeared in support of maintaining local authority of CMHCs. The subcommittee then passed Recommendation 10. Some observers at TDMHMR and CMHCs, and persons interested in the CMHC movement, remain unconvinced that this issue has been resolved and expect discussion to continue in the full committee meeting.

Conclusion

While the final role and effect of this committee's work remains open to some speculation, it is clear that the committee will present its final report to the Legislature in September 1980. Its recommendations, which could play a significant role in shaping future mental health policies in the state, presently do not focus on issues of appropriateness of mental health services for Mexican Americans and other ethnic and racial minorities.

NOTES ON THE SPECIAL COMMITTEE ON DELIVERY OF HUMAN SERVICES IN TEXAS (SR 67)

COMMITTEE MEMBERS

Listed below are the names of the committee members with their city and county and occupation, where known.

*Chair, Helen Farabee, Wichita Falls, TX (Wichita Co.)

*Vice-Chair, Senator Chet Brooks, Pasadena, TX (Harris Co.)

Morris Atlas, McAllen, TX (Hidalgo Co.), Attorney

Rebecca Canning, Waco, TX (McLennan Co.)

Joaquin G. Cigarroa, Jr., M.D., Laredo, TX (Webb Co.), Physician

John E. Codwell, Ph.D., Houston, TX (Harris Co.), Retired, Houston Independent School District

*Frank C. Erwin, Jr., Austin, TX (Travis Co.), Attorney

Senator Bill Meier, Euless, TX (Tarrant Co.)

*Commissioner Ann Richards, Austin, TX (Travis Co.), County Commissioner

Max Sherman, Canyon, TX (Randall Co.), President, West Texas State University

Senator W.E. (Pete) Snelson, Midland, TX (Midland Co.)

*Serves on Subcommittee on MH/MR Issues

Minutes of the MH/MR Subcommittee and Committee may be attained from:

Special Committee on Delivery of Human Services in Texas
712 Sam Houston Building
Austin, TX 78711
(512) 475-1284

FEDERAL LEGISLATIVE NOTES

ITEM: On April 14, 1980, the U.S. Civil Rights Commission held hearings in Washington, D.C. on health care. The hearings were convened because the commission had found "evidence that minority American women, older and handicapped persons receive less adequate health care," which is linked to the underrepresentation of women and minorities in the medical professions. Testimony was heard calling for a "major reexamination of federal and state policies affecting the health and social needs of the disadvantaged."

ITEM: It seems certain that Title XX, the Social Services Program, will be refunded in FY 1981 for \$2.9 billion. When this funding ceased in spring 1980, many CMHCs in Texas were forced to cut services and reduce staff. It is hoped that services in CMHCs will be reinstated, however, at this time it appears doubtful.

Note: Material in this section comes from the *Health Systems Report*, *TDMHMR Resource Memorandum* and *The Washington Post*.

MEXICAN AMERICAN WOMEN and SOCIAL SCIENCE RESEARCH

Too Often Subjects, Too Seldom Investigators

by Sally J. Andrade

There have been several efforts among Mexican American scholars to examine the problem of bias or neglect of Mexican American women or Chicanas¹ in the social sciences (e.g., Chapa & Andrade, 1976; Cotera, 1976; Sanchez & Cruz, 1977). Despite these efforts, this review of the literature will suggest that the social sciences continue to portray the Mexican American woman in a stereotyped manner. The three major topics of the review address the existing social science stereotypes of Chicanas, some more recent research concerning those stereotypes, and the policy implications of the stereotypes for institutions of higher education and educational research organizations. The author concludes that issues of affirmative action for Chicanas and resistance to institutional research on related topics are linked to the tenacity with which the social sciences have perpetuated stereotypes about Mexican American women.

Research on the Mexican American Woman

The general treatment of Mexican American women in social science research literature raises several important issues. As is noted in the demographic profile reported in this newsletter, Mexican American women are hindered by numerous socio-economic factors. It is necessary, however, to distinguish between critiques of the reliability of such demographic data and concerns about the objectivity of interpretations offered for the existence of such a disadvantaged situation. The most common explanation is that of cultural differences. Mexican American values are portrayed as differing significantly from those of Anglos and Blacks with regard to their perception of large families. The two concepts which are often emphasized are *machismo* (the Mexican American man's self-esteem is described as being determined by how many children he procreates) and *familism* (the Mexican American woman is viewed as defining herself almost exclusively in a maternal role).

The typical portrait of the Chicana in the literature is that of a mother figure, pleased and obliged to produce large families due to a system of rigidly defined sex roles. The Mexican American woman is further presented as submissive, self-sacrificing and passive, dominated by the male (Clark, 1959; Kiev, 1968; Madsen, 1961, 1964; Rubel, 1966). Her status is described as being defined by her maternal role rather than her occupation or education (Johnson, 1970; Moore, 1970). There is also a trend to draw from Mexican authors (e.g., Bermudez, 1955; Díaz-Guerrero, 1975) to support the portrait of male dominance within the family and a posture of inertia by Mexican women. A major discussion of Mexican American fertility for the U.S. Commission on Population Growth concludes that the "cultural context of childbearing" is the most significant explanation for the group's high fertility (Bradshaw & Bean, 1972). Thus, an exaggerated "super-mother" figure emerges from such impressions about Mexican

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American women: the unceasingly self-sacrificing, ever fertile woman totally without aspiration for self or initiative to do other than reproduce.

It is important to assess the quality of such research. A number of the studies from which the above interpretation has emerged were done in primarily rural settings, and almost all of them investigated lower-class samples. The impact of World War II and the dramatic shift from rural to urban areas by Mexican Americans has still not been fully recognized. Much of the data gathering and/or interpretation was done by Anglos, many of them males, who may not have received accurate information regarding sexual roles in the Mexican American culture and who perhaps were unaware of the discrimination and bias faced by the group. Oftentimes the size and selection of samples is questionable. The lack of operational definitions permitting behavioral tests is matched only by the lack of empirical data.

A Different Research Perspective on Chicanas and Family Roles

Several studies of family dynamics within Mexican American families have challenged the traditional portrayal of Chicanas. The assumed male dominance/female submissiveness pattern does not hold when couples are interviewed with regards to decision-making and action-taking (Hawkes & Taylor, 1975) and marital satisfaction, the employment of wives and egalitarianism (Bean, Curtis & Marcum, 1977). Cromwell & Ruiz (1979) undertook an intensive analysis of four major studies on marital decision-making in Mexican and Chicano families in an effort to examine the *machismo* or male dominance concept. They concluded that the available empirical evidence fails to substantiate the hypothesis of male dominance in marital decision-making. Their work is important both because it challenges the male-dominance myth, noting that the stereotype is perpetuated through impressionistic essays, and because the study identifies the roots of the stereotype as being embedded in the social pathology model of Hispanic life and culture rather than a realistic model. The implication for Mexican American women, as they point out, is the need to question the myth about Hispanic women's alleged submissiveness.

Another important issue is the fact that socioeconomic status has been consistently confounded with ethnicity in research on Mexican Americans. For example, the limited educational opportunities available to Mexican Americans explain the group's unusually high fertility (Uhlenberg, 1973) and the small proportion of Mexican American women in the labor force (Cooney, 1975).

Investigations of Mexican American attitudes and behaviors in relation to family planning are a third area

that challenge the traditional stereotype. Research has documented the vulnerability of the Mexican American woman as she seeks to become a client in the health care delivery system. Because she has a limited education, her lack of information about reproduction and sexuality blocks her interaction with medical personnel (Kay, 1972). The lack of compatibility between the Anglo, English-speaking, middle-class health care delivery system dominated by physicians and the Mexican American, Spanish-speaking, lower-class woman without a high school education is viewed as a major barrier (Urdaneta, 1976). In contrast, studies of Mexican American college students have shown that Chicanas were often the most positive advocates of birth control measures in described cases of genetic risk and more accepting of therapeutic abortion than either Mexican American males or Anglo males (Naranjo, 1976) and that cultural identification factors do not explain the family planning attitudes or contraceptive behaviors of Chicanas (Andrade, 1979).

Other research is beginning to challenge the stereotypes about assumed differences in values between Mexican Americans and Anglos. For example, Esparza (1977) studied motivational factors related to fertility behavior among low-income couples, comparing Mexican Catholics, Mexican American Catholics, Anglo Catholics and Anglo Protestants. The results provide a much more complex picture of group differences and similarities. Mexican American Catholics were closer to the positions of Anglo Catholics on some issues than they were to Mexicans, whereas other topics cut across ethnic lines with women being more in accord than men.

What is one to make of the suffering "super-mother" figure described earlier which dominates the public image of Mexican American women in contrast to the various images that emerge from the research cited in this section? It gives one serious cause for reflection about the durability of the stereotype. One Chicana reflects on the growing criticism among Mexican American academicians regarding the validity of such a narrow and empirically questionable view of Mexican American women and their families:

Their concern is, to what extent social scientists and the media are dictating norms to the Chicano family and to what extent are social planners and educators being influenced by these images. (Cotera, 1976, p. 154)

The myth has amazing tenacity. Apparently, many social scientists are too limited by their own cultural values and assumptions or by romantic stereotypes to perceive the actual heterogeneity of Mexican American families.

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Research

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Implications for Educational Policy and Research

One of the major dilemmas confronting a conscientious researcher is how to develop and cultivate a more objective and comprehensive understanding of Mexican American women. The conclusion seems inescapable that we cannot have sufficient quality research about Chicanas without the participation of trained and experienced Chicana researchers. The reliability and validity of our research remains doubtful so long as their perspective is missing.

Since our public education system continues to promote practices leading to a situation in which most Mexican American women complete less than ten years of school, profound changes are required before we can hope to see the number of Chicanas in college and in educational/psychological research that are needed. Specific factors that must be addressed include the secondary school counselors' expectations of minority females; the lack of attention to minority females within affirmative action programs in universities and business; and failure by funding sources and professional academic organizations representing the various social science disciplines to face their responsibilities in addressing the systemic bias in research on Chicanas and other minority women.

A priority for educational researchers must be more comprehensive investigations of the educational settings and systems within which Chicanas are struggling to survive. There should be less research on the personality and cultural variables of individual Chicanas and more on the white, middle-class educators and administrators who determine which students will attain success within public schools and universities.

As an example, a recent study by the Texas Advisory Committee to the U.S. Civil Rights Commission documented conclusively that:

There was a conspicuous absence of both minorities and females, particularly minority females, throughout the policymaking, key decision-making, and top administrative positions in the State system of public education. (Texas Advisory Committee, 1980, p. 187)

They argue that "the Texas tradition of placing minorities and women in lower paying, less prestigious jobs having little or no responsibility for affecting policy decisions" continues. It is, therefore, difficult to accept any explanation focusing on the cultural characteristics of Mexican American women when the issue of institutional racism, confounded by sexism, continues to dominate our nation.

MHRP Newsletter

Conclusion

The interpretation of data all too often lies in the eye of the beholder. To combat this "limited version," our emphasis must be on defining research problems in a manner sensitive to institutional biases as well as to cultural factors, on gathering data that validly reflect the social ecology of our target population rather than that of academia, and on interpreting the resultant data with a true objectivity by acknowledging the male orientation and ethnocentrism which have traditionally dominated the social sciences. Until we can free ourselves of stereotypic cultural expectations about the Chicana, our research will continue to be as distorted and, unfortunately, as irrelevant to social policy as it has been in the past.

NOTES

¹The terms Mexican American woman and Chicana are used interchangeably to denote female residents in the United States who are of Mexican origin.

REFERENCES

- Andrade, S.J. Family planning practices of Mexican Americans. In M.B. Melville (Ed.), *Twice a minority: Mexican American women*. St. Louis, C.V. Mosby, 1980.
- Bean, F.D., Curtis, R.L., Jr., & Marcum, J.P. Familism and marital satisfaction among Mexican Americans: The effects of family size, wife's labor force participation, and conjugal power. *Journal of Marriage and the Family*, 1977, 39, 759-767.
- Bermudez, M.E. *La vida familiar del mexicano*. Mexico, D.F.: Antigua Libreria Robredo, 1955.
- Bradshaw, B.S. & Bean, F.D. Some aspects of the fertility of Mexican Americans. In C.F. Westoff & R. Parke, Jr. (Eds.), *Demographic and social aspects of population growth* (Vol. 1, Research Reports of the U.S. Commission on Population Growth and the American Future). Washington, D.C.: U.S. Government Printing Office, 1972.
- Clark, M. *Health in the Mexican American culture*. Berkeley: University of California Press, 1959.
- Cooney, R.S. Changing labor force participation of Mexican American wives: A comparison with Anglos and Blacks. *Social Science Quarterly*, 1975, 56, 252-261.
- Cotera, M.P. *Diosa y hembra: The history and heritage of Chicanas in the U.S.* Austin: Statehouse Printing, 1976.
- Cromwell, R.E. & Ruiz, R.A. The myth of macho dominance in decision-making within Mexican and Chicano families. *Hispanic Journal of Behavioral Sciences*, 1979, 1, 355-373.

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DEMOGRAPHIC PROFILE OF MEXICAN AMERICAN WOMEN

Recent data on Mexican American women indicate that:

- The majority of Mexican American women live in urban areas, since more than 81 percent of the Mexican American population in 1978 was urban (U.S. Bureau of the Census, 1978).
- 21% of Spanish-origin families, of which approximately 60% are Mexican American, were reportedly below the poverty level in 1977 (U.S. Bureau of the Census, 1979).
- One out of every two Spanish-origin female-headed families existed below the poverty level in 1977 (U.S. Bureau of the Census, 1979).
- The median income for Mexican-origin women in 1977 was \$3,351 (U.S. Bureau of the Census, 1980).
- The families maintained by Mexican American women tend to be generally larger than families in the total population, with over 23 percent consisting of five or more persons (U.S. Bureau of the Census, 1980).
- Secondary analyses of Census data on children ever born to women aged 35 to 44 concluded that, in 1969, Mexican-origin women tended to have about 47 percent more children than all other women (Bradshaw & Bean, 1972).
- About 28 percent of Mexican-origin women have never married, while approximately 16 percent are either widowed, divorced, or married with husband absent (U.S. Bureau of the Census, 1980).
- Almost 47 percent of Mexican-origin women are 19 years of age and under, with close to 38 percent being under the age of 16; only 31 percent of non-Spanish-origin women are 19 and under (U.S. Bureau of the Census, 1980).
- The median age for women of Mexican origin, for example, is 21.3 years, in contrast to the national median for non-Spanish-origin women of 31.2 years (U.S. Bureau of the Census, 1980).
- Fourteen percent of women of Mexican-origin are under the age of five years, whereas only 6.4 percent are in the non-Spanish-origin population (U.S. Bureau of the Census, 1980).

- In terms of the elderly, a much lower proportion of Mexican-origin women were 65 years and over (3.9%) than were women not of Spanish-origin (12.5%) (U.S. Bureau of the Census, 1980).

- Most Mexican American women 25 years and above (68 percent) have not completed high school. For women in the age bracket of 25 to 34, the picture is somewhat brighter in that about 46 percent do graduate. However, less than 4 percent of Mexican-origin women 25 years and older have completed four or more years of college (U.S. Bureau of the Census, 1980).

- 11.4 percent of Mexican-origin women in the civilian labor force are unemployed, in contrast to 6.9 percent for women not of Spanish-origin (U.S. Bureau of the Census, 1980).

- The majority of working Mexican American women fall into three occupational categories: clerical (28%), operatives, including transport (26%), and service workers (25%) (U.S. Bureau of the Census, 1980).

SOURCES

Bradshaw, B.S. & Bean, F.D. Some aspects of the fertility of Mexican Americans. In C.F. Westoff & R. Parke, Jr. (Eds.), *Demographic and social aspects of population growth*, (Vol. 1, Research Reports of the U.S. Commission on Population Growth and the American Future). Washington, D.C.: U.S. Government Printing Office, 1972.

U.S. Bureau of the Census. *A statistical portrait of women in the U.S.: 1978*. (Current Population Reports: Special studies, Series P-23, No. 100). Washington, D.C.: U.S. Government Printing Office, 1980.

U.S. Bureau of the Census. *Persons of Spanish origin in the United States*. (Current Population Reports: Advance report, Series P-20, No. 328). Washington, D.C.: U.S. Government Printing Office, 1978.

U.S. Bureau of the Census. *Persons of Spanish origin in the United States*. (Current Population Reports: Population characteristics, Series P-20, No. 339). Washington, D.C.: U.S. Government Printing Office, 1979.

DEPRESSION IN MEXICAN AMERICAN WOMEN:

IMPLICATIONS FOR COMMUNITY MENTAL HEALTH SERVICES

by Sharon Sepúlveda Hassell

Depression is a widespread mental health disturbance that affects countless individuals, in particular women, with varying degrees of severity. It indirectly touches the lives of many more people as a result of the impairment in social and familial functioning experienced by depressed women. The extensive research and clinical attention that have been directed toward the study of the causes of depression recently have expanded to include recognition of the social environment's influence upon the incidence of depression. Mexican American women, the majority of whom are low-income, are subjected to numerous negative socio-cultural environmental influences and frequently possess the social and economic characteristics of the population-at-risk with regard to depressive disorders. As deliverers of local mental health services, community mental health centers (CMHCs) can play an important role in recognizing and reducing the socio-cultural obstacles within their communities that impair the mental health and general well-being of low-income Mexican American women. The changing trends in thought regarding the origins of depression and their implications for the delivery of mental health services at the community level to low-income Mexican American women, as well as the potential role of the CMHCs in treating this disturbance, will be explored in this article.

The Incidence of Depression in Women

Numerous research studies have substantiated the incidence of depression disorders across ethnic, cultural, social and economic lines. Despite the universality of depression, the characteristic symptomatic feelings of helplessness, hopelessness, anxiety, low sense of self-esteem, and impaired physical and social functioning afflict substantially more women than men. The extensiveness of depression in women is illustrated by the following:

Schuyler (1974) reported estimates that one out of every five women will experience clinical depression within her lifetime.

Women are assessed to be depressed twice as often as men (Fisher, 1978).

Depressive disorders are the leading diagnoses of women reported by a range of mental health facilities (Fisher, 1978).

Young, poor, female heads of families and young married mothers working in low-level jobs have experienced the greatest increases in the incidence of depression (Fisher, 1978).

The incidence of depression among Mexican Americans has likewise been documented. A survey of mental health service recipients at a Tucson *barrio* clinic noted that depression and anxiety were the most prevalent

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symptoms reported (Ruiz, Casas & Padilla, 1977). A cross-cultural psychiatric study comparing Anglo American and Mexican American women engaged in psychotherapy identified depression as a basic element of the emotional disturbance experienced by the Mexican American women (Ruiz et al, 1977). In consideration of the extensively documented underutilization of mental health services by Mexican Americans, it is reasonable to question the impact of mental health services delivered to depressed low-income Mexican American women. The traditional psychotherapeutic and pharmacological services offered to depressed women are based upon a range of theoretical explanations regarding the onset of depressive disorders. Following a brief overview of the prevailing traditional theories, the importance of considering the impact of the socio-cultural environment in the treatment of the depressed low-income Mexican American women is elaborated.

Theories About the Origins of Depression

Numerous conceptual models of the origin of depression have been granted. Although there is substantial agreement that there is no one cause of depression, traditionally many researchers have emphasized the psychological or physiological makeup of the depressed woman. The psychological models emphasize unresolved psychic conflicts, internalized anger (Freud, 1934), and other intrapersonal variables such as cognitive disorders (Beck & Greenberg, 1974) that result in impaired functioning which may deteriorate into depression. The proponents of physiological models have investigated genetic links and biochemical imbalances as possible origins of depression in women (Akiskal & McKinney, 1975; Fisher, 1978; Winokur, Carodet & Dorzab, 1971).

Environmental or socio-cultural factors linked to the incidence of depression in women have also been studied and constitute a new and growing school of thought regarding causes of depression. Weissman & Klerman (1977) proposed social status and socialization hypothesis relating the social roles and adaptations of women to their high incidence of depression. Closely associated with the concept that women have traditionally been socialized to be helpless and dependent, characteristic feelings associated with depression, is the socio-cultural explanation that depression is an acceptable outlet of negative feelings for women. Wetzel (1978) developed a person-environment incongruence model regarding depression in women which hypothesized that, "...dependence upon unsustaining environments is an antecedent variable of depression." Although all these theoretical explanations undoubtedly have some applicability for explaining the incidence of depression in low-income Mexican American women, the fact that social environmental factors may predispose depression is particularly relevant for that population.

Environmental Stresses Affecting Mexican American Women

The low-income Mexican American female is subject to numerous environmental stresses that erode her ability to develop personal autonomy and decrease her power to exercise control over her life, which can lead to symptoms of depression. As the demographic profile reported in this newsletter indicates, many Mexican American females live in or head families that exist below the poverty level. The limited educational backgrounds of the majority of Mexican American women impede their employment opportunities. Consequently, the majority of Mexican American women are either unemployed or underemployed. The lack of adequate bilingual-bicultural child care facilities and accessible urban mass transit systems further restrict the Mexican American woman's opportunities to develop her personal, economic and social resources. These factors as well as other social and environmental stresses impacting upon the lives of many Mexican American females were succinctly enumerated by Boulette to include:

... overt and covert prejudice; pervasive poverty; ineffective and/or insufficient education; extremely high unemployment and/or underemployment; overcrowded and dilapidated housing; low levels of health and health information; difficulties with English fluency; stresses inherent to acculturation and immigration; high rates of alcohol and "hard drug" addiction; and father absence due to marital disruption, incarceration, and lack of local employment. (Boulette, 1976, p. 67)

Research continues into further substantiation that the environmental factors noted above are directly related to a high incidence of depression within the population of low-income minority women. A study by Quesada, Spears & Ramos (1978) of interracial depressive epidemiology among Mexican Americans and Blacks in the Southwest corroborated that the awareness of the existence of societal structural barriers by lower socioeconomic groups is positively correlated to high rates of depression. Social, political and economic environments do significantly influence the existence of depressive disorders among low-income Mexican American women and must be given consideration in the design of treatment services and mental health policies that are intended to serve this population.

Treatment Implications

Numerous researchers and clinicians engaged in the development of treatment modalities appropriate for Mexican Americans note the relationship of the socio-cultural environment to disturbances in individual functioning (Boulette, 1976; LeVine & Padilla, 1980). Ruiz (1977) delineated the distinction between internal and

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Depression

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external variables related to individual dysfunction as being intrapsychic or extrapsychic stresses. Intrapsychic stresses are experienced by all individuals and can become mental health problems if the psychological resources of the individual are unable to cope with and resolve disturbances. Extrapsychic stresses, however, are linked to the numerous socio-cultural barriers imposed by the larger social system, many of which impact upon Mexican Americans. If it is acknowledged that a non-supportive environment may be an antecedent to depression, it is unreasonable to probe strictly into the depressed person's psychic, behavioral, or biochemical processes for resolution of their dysfunction. According to Ruiz:

The treatment approach that alleviates intrapsychic depressions (some combination of medication and supportive and insight psychotherapy) is of little help in minimizing extrapsychic depressions associated with discrimination from the larger society. Furthermore, the basic problem – a prejudicial society – remains untouched and unchanged by a mental health treatment approach aimed at individual "pathology." (Ruiz, 1977, p. 236)

The development of insight and coping skills, as well as the enhancement of personal resources emphasized in traditional therapeutic approaches is generally useful to depressed recipients of mental health services. In addition, however, particular attention must be paid to the social systemic factors that contribute to the depressed feelings and behaviors of low-income Mexican American women. Otherwise, the entire responsibility for the depressive dysfunction is placed upon the individual which is a variation of the "blaming the victim" mentality (Ryan, 1976). Furthermore, traditional therapeutic approaches that do not acknowledge individual-societal interactions and fail to integrate a systems approach into the delivery of services to low-income Mexican American clients may continue to be irrelevant and unproductive, however, well-intentioned.

Recommendations for Community Mental Health Centers

Community mental health centers can and should play an important role in treating low-income Mexican American women who suffer from depression. As community-based services, CMHCs are in a position to observe and assess the extent of the local community's supportive or obstructionist attitudes toward the mental health and general well-being of Mexican American residents. If the incidence of treated and untreated cases of depression among low-income Mexican American women is to be reduced, mental health service deliverers must become sensitive to the existence of socio-cultural

barriers and work toward the elimination of such obstacles. Initially, mental health services deliverers must revise their thinking regarding the causes of depression among low-income Mexican American women. Factors which must be acknowledged include:

- environmental liabilities such as substandard housing;
- inaccessible or poorly-equipped medical facilities;
- inadequate educational facilities;
- lack of available employment opportunities;
- limited access to mass transit systems;
- lack of bilingual/bicultural child care centers; and
- inequitable allocations of community funds and public service resources to Mexican American *barrios*.

Community mental health service providers can then serve as client advocates and become involved in local, social and political processes that largely affect the quality of life for residents. Mental health providers can thus integrate a change-oriented advocacy role into the traditional psychotherapeutic and pharmacological interventions primarily delivered to depressed women. Such an approach is essential to the delivery of meaningful mental health services to depressed low-income Mexican American women but may well have potential relevance for numerous other community mental health service recipients.

REFERENCES

- Akiskal, H.S. & McKinney, W.T. Overview of recent research in depression. *Archives of General Psychiatry*, 1975, 32, 285-305.
- Beck, A.T., & Greenberg, R.L. Cognitive therapy with depressed women. In V. Franks & V. Burt (Eds.), *Women in therapy*. New York: Bruner/Mazel, Inc., 1974.
- Boulette, T.R. Assertive training with low-income Mexican American women. In M.R. Miranda (Ed.), *Psychotherapy with the Spanish-speaking: Issues in research and service delivery*. Los Angeles: Spanish-speaking Mental Health Research Center, 1976.
- Boulette, T.R. *Determining needs and appropriate counseling approaches for Mexican American women: A comparison of therapeutic listening and behavioral rehearsal*. San Francisco, CA: R and E Research Associates, 1976.
- Fisher, A.E. *Women's worlds: NIMH supported research on women* (NIMH Monograph, U.S. Department of Health, Education and Welfare Publication No. (ADM) 78-660). Washington, D.C.: U.S. Government Printing Office, 1978.

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THE VIEW FROM THE DITCH*

Research on the Hispanic community must dispel common stereotypes rather than reinforce them, said Ramiro Valdez of the Intercultural Development Research Association in San Antonio, Texas. He particularly criticized the image of Hispanic youth as street gang members and the negative macho image of the Hispanic male.

"Macho was a compliment in Spanish," Valdez said, "but in English the positive connotations have been lost and the word has become an insult." Rather than perpetuate the myth of the "drunkard, fighter, cheater, wifebeater, authoritarian" Hispanic male, studies should focus on the "view from the ditch," said Valdez, referring to the dire economic circumstances of many Hispanic families.

These economic straits have affected youth employment in both positive and negative ways, Valdez pointed out. Because of low family income, many young people

are forced to drop out of school to help support themselves and the rest of the family. "They will have to work longer and harder to break out of poverty," Valdez said.

Despite this, he continued, most Hispanic families have managed to stay together, and their struggle has developed such positive traits as loyalty, strength of character, persistence, resourcefulness, and discipline.

The best thing employment and training programs can do for Hispanic youth is to keep the head of the household employed, Valdez said. Besides providing a positive role model for young people, this would prevent 14-year-olds from having to leave school.

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Research

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Diaz-Guerrero, R. *Psychology of the Mexican*. Austin: University of Texas Press, 1975.

Esparza, R. The value of children among lower class Mexican, Mexican American and Anglo couples (Doctoral dissertation, University of Michigan, 1977). *Dissertation Abstracts International*, 1977, 38, 1397-B. (University Microfilms No. 77-17, 991).

Hawkes, G.R. & Taylor, M. Power structure in Mexican and Mexican American farm labor families. *Journal of Marriage and the Family*, 1975, 37, 807-811.

Johnson, C.A. *Fertility differentials among Mexican Americans of the five south-western states*. Unpublished doctoral dissertation, The University of Texas Health Science Center at Houston, 1970.

Kay, M.A. *Health and illness in the barrio: Women's point of view*. Unpublished doctoral dissertation, University of Arizona, 1972.

Kiev, A. *Curanderismo: Mexican American folk psychiatry*. New York: Free Press, 1968.

Madsen, W. *Society and health in the Lower Rio Grande Valley*. Austin: Hogg Foundation for Mental Health, 1961.

Madsen, W. *The Mexican Americans of South Texas*. New York: Holt, Rinehart & Winston, 1964.

Moore, J.W. *Mexican Americans*. Englewood Cliffs, N.J.: Prentice-Hall, 1970.

Naranjo, M.S. *Cross-cultural comparison of social psychological factors contributing to the effectiveness of genetic counseling therapy*. Unpublished master's thesis, The University of Texas at Austin, 1976.

Rubel, A.J. *Across the tracks: Mexican Americans in a Texas city*. Austin: The University of Texas Press, 1966.

Sanchez, R. & Martinez Cruz, R. (Eds.), *Essays on La Mujer*. Los Angeles: Chicano Studies Center Publications, UCLA, 1977.

Texas Advisory Committee to the U.S. Commission on Civil Rights. *A report on the status of minority group members and women in public employment and public education in Texas during 1977*. Status of Civil Rights in Texas, Vol. III. Washington, D.C.: U.S. Commission on Civil Rights, 1980.

Uhlenburg, P. Fertility patterns within the Mexican American population. *Social Biology*, 1973, 20, 30-39.

Urdaneta, M.L. Chicana use of abortion. In M.B. Melville (Ed.), *Twice a minority: Mexican American women*. St. Louis: C.V. Mosby, 1980.

Depression

cont. from pg 10

- Freud, S. Mourning & Melancholia. In J. Riviere (Ed. and trans.), *Collected Papers*. London: Hogarth Press, 1934.
- LeVine, E.S., & Padilla, A.M. *Crossing cultures in therapy: Pluralistic counseling for the Hispanic*. Monterey, CA: Brooks/Cole, 1980.
- Quesada, G.M., Spears, W., & Ramos, P. Interracial depressive epidemiology on the Southwest. *Journal of Health and Social Behavior*, 1978, 19, 77-85.
- Ruiz, R.A. The delivery of mental health and social change services for Chicanos: Analysis and recommendations. In J. L. Martinez (Ed.), *Chicano psychology*. New York: Academic Press, 1977.
- Ruiz, R.A., Casas, J.M., & Padilla, A.M. *Culturally relevant behavioristic counseling*. Los Angeles: Spanish-speaking Mental Health Research Center, Occasional Paper No. 5, 1977.
- Ryan, W. *Blaming the victim*. New York: Vintage, 1976 (revised edition).
- Schuyler, D. *The depressive spectrum*. New York: Aronson, 1974.
- Weissman, M.M., & Klerman, G.L. Sex differences and the epidemiology of depression. *Archives of General Psychiatry*, 1977, 34, 98-111.
- Wetzel, J.W. Depression and dependence upon unsustaining environments. *Clinical Social Work Journal*, 1978, 6, 75-89.
- Winokur, G., Carodet, R., & Dorzab, J. Depressive disease: A genetic study. *Archives of General Psychiatry*, 1971, 24, 135-144.



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NEWSLETTER OF THE MENTAL
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Vol. 2 No. 3

A Preliminary Analysis of the Patterns of Use of Community Mental Health Services in Texas

by David G. Ramirez

Without a doubt one of the most researched issues in the area of Mexican American mental health is the paradox of their underutilization of mental health services. This study will again test the underutilization hypothesis, but will use a more refined method than has been possible in the past. Such an effort is warranted due to the methodological flaws inherent in previous research on the underutilization of mental health services by Mexican Americans. The majority of the Mexican American population daily endures the stresses of poverty, poor housing, inadequate education, poor nutrition and discrimination in job opportunities. Despite the documented relationship of some of these conditions, the most notable of which is poverty, with a greater incidence of mental illness (Hollingshead & Redlich, 1978; Srole, Langer, Michael, Opler & Rennie, 1962), the Mexican American population has often been shown in past research to underutilize mental health services (Jaco, 1959; Karno & Edgerton, 1969; Kruger, 1974; Bachrach, 1975; Cuellar, 1977). The results of this statistical analysis corroborate the underutilization trend with regard to usage of community mental health centers by Mexican Americans in Texas.

Previous Research

The difficulty in accepting the findings of previous utilization research has stemmed from inadequate methodology. The three primary difficulties that have emerged in this area are: 1) the data sets used to calculate the differential rates were too gross in magnitude to allow for specific analysis (examples: Jaco, 1959; Karno & Edgerton, 1969), 2) the statistical techniques chosen (often due to the limitations of the data) did not allow the researcher sufficient data points to make reliable comparisons between ethnic groups (examples: Kruger, 1974; Cuellar, 1977), and 3) the denominators used in the generation of the utilization rates have been only marginally accurate (rates are generally produced by dividing the number of

individuals served within a specific time period from a specific area by the number of people of this group which reside in the area).

Method

This study has minimized each of the above concerns substantially, thus rendering the research results far more useful and reliable. To minimize the first difficulty (comparing rates of various population groups of a very large area to each other), each of the 28 community mental health service areas operational in 1978 in the state of Texas was treated as a separate community or area for study. This was accomplished by aggregating the data of the various counties in Texas which comprised each service area. In addition, each of these 28 service areas was further subdivided into the 15 separate population groups shown in Figure 1 on pg. 2.

In this study, only the rates for ALL AGES combined were analyzed. Table 1 (pg. 3) shows the data utilized in the series of statistical tests reported herein. Subsequent studies will discuss the patterns of utilization found across age, sex, ethnicity, service type and centers.

As an example of the method used to generate the rates, the population statistics of the service area of the Bexar County Community Mental Health Center (which includes only Bexar County) were subdivided into the 15 groups described. For example, the number of Mexican Americans from birth to twelve years of age who reside in Bexar County formed the denominator for this particular group. Given the lack of current population data, it was necessary to obtain accurate estimates for the number of residents in each service area by age group and ethnicity for the year 1978. Data from 1978 were needed because the utilization data analyzed were reported for that time period. Utilizing recognized demographic techniques, the projected population sizes were generated through the use of two formulas (Shyrock and Siegel, 1976), and census data obtained for 1960, 1970 and 1975.

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Analysis

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Population estimates for each of the subgroups were generated. This process involved the computation and generation of population estimates for 336 subgroups (28 service areas x 3 ethnic groups x 4 age categories).

Subsequently, corresponding numbers of users of services for each of the subgroups were acquired from the computer files of the Texas Department of Mental Health and Mental Retardation. These figures formed the numerators in the generation of the utilization rates.

Three products were then generated: 1) crude utilization rates per thousand (the ALL AGES columns); 2) age specific utilization rates per thousand by ethnicity listed in four groups, 0-12, 13-20, 21-64, and 65+; and 3) each of the above breakdowns were further listed by general services categories, i.e., mental health, alcoholism, drug abuse, mental retardation, no diagnoses, total served, total served excluding mental retardation, and further separated by sex. A total of 21 tables of utilization rates were produced by this method. The present study only analyzed the composite data for all ages seen in Table 1.

Given the literature on the paradox of underutilization of mental health services, the first test that must be performed is an assessment of the rates generated for the users of mental health services (see Table 1). A number of the previous studies conducted in this area have analyzed their data, center by center, using the chi square statistic. Such a method is more likely to find differences between groups which are due to a range of extraneous factors which may not be related to the key variable under study. The availability of comparably generated rates for 28 community mental health centers allows for the use of statistics that can make some adjustments for the inevitable variability across centers and communities with reference to their delivery of services to the Mexican American population. In other words, by analyzing the data on 28 centers simultaneously rather than one at a time, the study can more adequately determine whether a lower rate of use is simply due to a deluge of intervening variables (in the one center study) or is a consistent statistically significant pattern which emerges across centers.

To analyze the data, the statistics chosen were the Kruskal-Wallis one-way analysis of variance and the Mann-Whitney U test. Both of these tests are nonparametric and hence do not require the data to exhibit homogeneity of variance (although homogeneity of variance generally exists in this data) and random selection as do their parametric counterparts, the *F* and *T* tests. In addition, the power of the Kruskal-Wallis and Mann-Whitney U tests is fairly comparable to that of the *F* and *T* tests. For purposes of both the Kruskal-Wallis and Mann-

Figure 1

AGE AND ETHNIC GROUP DENOMINATORS

	0-12	13-20	21-64	65+	ALL AGES
Mexican American					
Anglo					
Black					

Whitney U tests, the data were converted to ranks for analysis. Essentially, the Kruskal-Wallis test determines whether the differences between the sum of the ranks of the groups (in this study, ethnic groups) is sufficiently large to approach statistical significance, and thus rejects the null hypothesis that each set of scores was drawn from the same basic population. The null hypothesis would assert that no differences exist between ethnic groups; thus, the sum of the ranks should be relatively equal. Again, across centers and within ethnic groups, considerable variance in rates is expected, but the Kruskal-Wallis test will determine (as will the *F* test) whether the differences between ethnic groups is larger than the differences within each group. Significance on the Kruskal-Wallis test (as with the *F* test) will only indicate that at least one of the three group rates is significantly different from one of the other groups. In order to determine where those key differences lie, a series of Mann-Whitney U tests was performed (which compare two groups at a time using the same basic logic involved in the Kruskal-Wallis test).

Findings

In this analysis, the ethnic group with the smaller sum of ranks will be the group whose rates of use were lower numerically. From analysis of the crude

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utilization rate data from the columns ANG, MEX A, BLK for ALL AGES (Table 1), the following pattern is obtained for the sum of the ranks: Anglo = 1181, Mexican American = 861, Black = 1528. Thus, the highest rate of use of mental health services was exhibited by Blacks, followed by Anglos, followed by Mexican Americans. The Kruskal-Wallis test indicated that significant difference(s) exists between one or more of these groups ($H = 13.36$, $p < .01$). In order to determine which group(s) differed, a Mann-Whitney U test was run with the following results: 1) between the Anglo and Mexican American groups ($U = 271.5$, $p < .0241$; significant differences, with Mexican Americans using less than Anglos); 2) between the Mexican American and Black groups ($U = 183.5$, $p < .0003$; significant differences, with Mexican Americans using less than Blacks); and 3) between the Anglo and Black groups ($U = 262.5$, $p < .0169$;

significant differences, with Anglos using less than Blacks). Thus, this comparison supports the predicted underutilization of services by Mexican Americans in relation to Anglos and Blacks.

The same analysis was run on the comparable figures for males only and females only with very similar results (see Figures 2 and 3 on pg. 4 for results).

Once again, each of the above set of findings essentially supports the existence of the underutilization of mental health services by Mexican Americans, which has been discussed in the literature. In addition, the methods utilized in this study provide a stronger basis of support for this finding.

Discussion

An additional issue must be raised in regard to the

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Table 1

UTILIZATION RATES PER THOUSAND FOR USERS OF MENTAL HEALTH SERVICES AT CMHCs IN 1978

CENTER	ALL AGES		
	ANG	MEX A	BLK
ABILENE REGIONAL MHMR CENTER	7.6	6.3	10.1
AMARILLO MHMR REGIONAL CENTER	5.7	6.6	5.3
MHMR CENTER-AUSTIN-TRAVIS COUNTY	9.0	8.1	13.6
BEXAR COUNTY MHMR CENTER	3.6	6.8	8.5
BRAZOS VALLEY MHMR CENTER	8.1	4.0	7.5
CENTRAL COUNTIES CENTER FOR MHMR SERVICES	7.0	4.9	6.6
CENTRAL PLAINS COMPREHENSIVE CMHMR CENTER	12.9	10.7	13.7
CENTRAL TEXAS MHMR CENTER	7.1	5.6	11.1
DALLAS COUNTY MHMR	6.9	5.5	12.5
DEEP EAST TEXAS REGIONAL MHMR SERVICES	9.9	5.9	8.2
MHMR REGIONAL CENTER OF EAST TEXAS	8.3	4.3	7.8
EL PASO CENTER FOR MHMR SERVICES	5.8	6.8	7.4
CONCHO VALLEY CENTER FOR HUMAN ADVANCEMENT	7.9	8.7	12.5
GULF BEND MHMR CENTER	13.4	13.7	13.7
GULF COAST REGIONAL MHMR CENTER	3.4	2.6	6.2
MHMR AUTHORITY OF HARRIS COUNTY	2.1	2.5	4.9
HEART OF TEXAS REGION MHMR CENTER	9.7	9.0	12.9
LUBBOCK REGIONAL MHMR CENTER	5.9	4.0	5.7
NORTHEAST TEXAS MHMR CENTER	6.7	6.7	6.3
NUECES COUNTY MHMR COMMUNITY CENTER	6.1	6.8	7.6
PECAN VALLEY MHMR REGION	6.0	1.2	2.5
PERMIAN BASIN COMMUNITY CENTERS FOR MH AND MR	15.8	16.1	20.6
SABINE VALLEY REGIONAL MHMR CENTER	8.4	0.0	7.6
MHMR OF SOUTHEAST TEXAS	5.2	2.2	8.7
TEXOMA REGIONAL MHMR CENTER	7.1	5.1	11.1
TARRANT COUNTY COMMUNITY MHMR CENTER	5.3	4.8	10.1
TROPICAL TEXAS CENTER FOR MHMR	4.5	3.8	7.7
WICHITA FALLS COMMUNITY MHMR CENTER	8.4	6.7	10.2

Analysis

cont. from pg. 3

strength and importance of these findings. Utilization studies in the past and in the present have made an implicit assumption due to their methodological structure. It is assumed that the need for services is relatively equal across ethnic groups (or randomly distributed in the general population). Thus, if 80 percent of the population in an area is Anglo, 10 percent Mexican American and 10 percent Black, researchers expect equivalent percentages in the client population. Rabkin & Struening (1976), having conducted a review of the literature pertaining to the influence of ethnicity in relation to the prevalence and incidence of mental illness, concluded:

It is generally acknowledged that psychiatric disorders are not distributed throughout populations, but tend to be concentrated within definable subgroups. The major dimensions historically associated with such variations are those of ethnicity, social class and immigration...

If one population group is in a higher risk of developing mental health difficulties due to poverty, discrimination or some other form of stress and thus is in greater need of services, the methods used in this and previous research would not adjust the utilization figures for the greater need. This line of reasoning is probably seldom stated because in most underutilization studies, numerical equivalency is not achieved. Thus, the probable additional need for services by Mexican Americans would only accentuate the underutilization finding.

Nevertheless, researchers who find equivalent numerical rates of utilization between Anglos and Mexican Americans must be cautious in interpreting their results as a case for equal access and use of services by Mexican Americans.

Although all of the above analyses represent only a fraction of the findings to be derived from the utilization rate data generated by the Mental Health Research Project, they do serve as an example of the depth and value of these rates for research in this area. Further analysis is being conducted and the results will be reported in a monograph which will detail the methods and possible reasons for the outcomes found.

References and Additional Sources

- Andrulis, D. P. Ethnicity as a variable in the utilization and referral patterns of a comprehensive mental health center. *Journal of Community Psychology*, 1977, 5, 231-237.
- Bachrach, L. L. Utilization of state and county mental hospitals by Spanish-Americans in 1972. (NIMH Division of Biometry, Statistical Note 116, DHEW Publication No. (ADM) 75-158). Washington, D.C.: U.S. Government Printing Office, 1975.
- Barrera, M. Mexican American mental health service utilization: A critical examination of some proposed variables. *Community Mental Health Journal*, 1978, 14(1), 35-45.

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Figure 2

MALES ONLY - Mental Health

	ANGLO	MEXICAN AMERICAN	BLACK
Sum of Ranks	1079.5	897.5	1593

Kruskal-Wallis test is significant ($H = 15.62, p < .001$)

- U tests
- 1) Anglo-Mexican American comparison ($U = 309.5, p = .0881$; only slightly approaching significance with Mexican Americans showing lower use than Anglos)
 - 2) Black-Mexican American comparison ($U = 182.0, p < .0003$; significant with Mexican Americans showing lower use than Blacks)
 - 3) Anglo-Black comparison ($U = 199.0, p < .0008$; significant with Anglos showing lower use than Blacks)

Figure 3

FEMALES ONLY - Mental Health

	ANGLO	MEXICAN AMERICAN	BLACK
Sum of Ranks:	1254	870.5	1445

Kruskal-Wallis test is significant ($H = 10.2, p < .01$)

- U tests
- 1) Anglo-Mexican American comparison ($U = 259.0, p < .0146$; with Mexican Americans showing lower rates of use than Anglos)
 - 2) Black-Mexican American comparison ($U = 205.5, p < .0011$; with Mexican Americans showing lower rates of use than Blacks)
 - 3) Anglo-Black comparison ($U = 323.5, p = .1308$ non-significant difference)

CMHC FINAL RULE PUBLISHED — FUNDING PERIOD UNRESOLVED

by Bernadette A. Brusco

On Friday July 18, 1980, the *Grants for Community Mental Health Centers; Final Rule* was published in the Federal Register (Vol. 45, No. 140). This rule establishes requirements for grants and applications for grants under the Community Mental Health Centers Act 1965 and all the ensuing amendments. While no new policies were established, some guidelines that had emanated from HEW over time are now formally part of the Rule.

Briefly summarized, the Rule:

1. Establishes more flexible and rational rules for designating poverty areas. In order to be so designated, a catchment area must meet at least one of the following criteria:
 - A. The catchment area must have 10 percent of its population below poverty cutoff -or-
 - B. The catchment area must contain at least one sub area with at least 15 percent of the population below poverty cutoff -or-
 - C. The sum of the population of sub areas of the catchment area, under A, must equal at least 35 percent of the population of the catchment area.
(If the catchment area cannot meet the requirements of A-C, there are five additional sub formulas which may be applied).
2. Requires applicants to disclose procedures for filling governing body vacancies; and to disclose certain information pertaining to potential conflicts of interest on the part of its members.
 - A. Implements the 1978 statutory amendments permitting certain grantees to establish an advisory committee in lieu of a governing body.
 - B. Requires grantees to describe how members of

FEDERAL NOTES

ITEM: The Senate version (S. 1172) of the Mental Health Systems Act was passed on July 24, 1980. The House version (H.R. 7299) will be considered August 18, 1980. Considerable controversy has accompanied this bill because of the proposed federal system of patient rights guarantees. This, however, has now been deleted. Unless new amendments are introduced, the Act fairly well maintains the status quo as established by the previous legislation.

ITEM: The Department of Health & Human Services (HHS) attempted to cut off funds to the Texas State

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the governing body represent the residents of the center's catchment area.

3. Clarifies state reporting and certain planning requirements.
 - A. State must set forth relative need in state plan
 - B. State must describe statistical procedures used in determination of relative need.
 - C. State must include assurances of community involvement in the planning process, particularly documentation and evidence that:
 1. a reasonable opportunity was afforded to interested agencies, organizations and individuals to present their views and to comment to the state agency upon the proposed plan;
 2. a reasonable opportunity will be afforded to interested agencies, organizations and individuals to comment to the state agency upon the administration of the plan proposed and any modification of the plan;
 3. a summary of those views and comments and the account, if any, which was taken of such views and comments; and
 4. a description of the various places in the state, which must have been readily accessible to the public, at which the proposed plan or modification thereof was made available and of the various places (also readily accessible) in the state at which the plan, including any modifications, continues to be available.

It is too early to evaluate the effect of the provisions of the final Rule on the 30 CMHCs in Texas. Ongoing research of the MHRP indicates that perhaps the state's planning process with regard to citizen input and agency responsiveness may have to be modified to meet the new requirements. Just how the new flexible poverty designation guidelines will benefit the poorer

cont. pg. 6

Health Planning and Development Agency (SHPDA) because of the SHPDA's failure to qualify for annual redesignation. The SHPDA failed to "identify in writing the portion of its certificate of need program that could be revised to conform with PL 96-79 without legislative change." However, a U.S. District Court in Texas temporarily barred HHS from stopping funds. A hearing on the court's restraining order is due shortly.

ITEM: As of July 30, 1980, the House Appropriations Health Subcommittee has completed work on the FY 1981 HHS Appropriation Bill. However, the figures will not be made public until after the full committee meets during the week of August 18, 1980.

Note: Material in this section comes from the *Health Systems Report*, *TDMHMR Resource Memorandum* and *The Washington Post*.

Analysis

cont. from pg. 4

- Cuellar, I. The utilization of mental health facilities by Mexican Americans: A test of the underutilization hypothesis. Unpublished doctoral dissertation. The University of Texas at Austin, 1977.
- Fiedler, F. P. *Utilization, Staffing and Community Profiles: Community Mental Health Mental Retardation Centers in Texas*. San Antonio: Intercultural Development Research Association, 1979.
- Flores, J. L. The utilization of a community mental health service by Mexican Americans. *International Journal of Social Psychiatry*, 1978, 24(4), 271-275.
- Hollingshead, A. G. & Redlich, F. C. *Social class and mental illness: A community study*. New York: Wiley 1958.
- Jaco, E. G. Mental health of the Spanish Americans in Texas. In M. F. Opler (Ed.), *Culture and mental health: Cross-cultural studies*. New York: Macmillan Co., 1959.
- Kruger, B. The relationship of ethnicity to utilization of community mental health centers (Doctoral dissertation, The University of Texas at Austin, 1974). *Dissertation Abstracts International*, 1974, 35, 2436-B. (University Microfilm No. 74-24887).
- Pokorney, A. D. & Overall, J. E. Relationship of psychopathology to age, sex, ethnicity, education, and marital status in state hospital patients. *Journal of Psychiatric Research*, 1970, 7, 143-152.
- Srole, L., Langer, T. S., Michael, S. T., Opler, M. K., & Rennie, T. A. C. *Mental Health in the Metropolis*, Vol. 1. New York: McGraw-Hill, 1962.
- Skyrock, H. S. & Siegel, J. S. *Methods and Materials of Demography*. New York: Academic Press, 1976.
- Trevino, F. M. & Bruhn, J. G. Incidence of mental illness in a Mexican American community. *Psychiatric Annals*, 1977, 7:12.

MHRP Seeking Applicants for Research Position

IDRA's Mental Health Research Project (MHRP) is currently seeking applicants for the position of researcher. The MHRP is a three-year NIMH funded study designed to assess the responsiveness of the Texas mental health service delivery system to the needs of Mexican Americans. Requirements for the position include a bilingual/bicultural M.A. (Ph.D. preferred) in the fields of psychology or sociology. In addition, experience in the areas of ecological or community psychology, field research, minority mental health, and multivariate statistics is requested. For further information, contact: David Ramirez, Project Director, Mental Health Research Project, IDRA, 5835 Callaghan Rd., Suite 350, San Antonio, Texas 78228 (512) 684-8180.

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CMHC Rule

cont. from pg. 5

communities is unclear. While designation may be easier without concurrent redefinition from the state on the local match of funds needed, most of these communities may be too poor to support a CMHC. All in all, the provisions of the final rule should be reevaluated in the future in order to ascertain its real impact.

One of the major issues still unresolved by the Rule is the extension of the eight-year funding life of CMHC grants. This question has been discussed during every Congressional session for the past five years but has never been resolved. In Texas, as of June 1, 1980, 14 of 30 CMHCs are no longer funded by federal CMHC staffing grants. (See Table 1 below.) Sixteen centers receive federal staffing funds, but as Table 2 (pg. 7) shows, 10 of these have less than one year remaining of the allowable award period. It is not clear at this time how many centers would elect to continue to receive federal staffing funds should that become an option. Some centers have voiced a disdain for the federal funds because of the accompanying federally imposed requirements.

TABLE 1

COMMUNITY MHMR CENTERS NOT FUNDED BY FEDERAL STAFFING GRANTS IN FY 1980*

Abilene Regional MHMR Center

Amarillo MHMR Regional Center

Central Plains Comprehensive
Community MHMR Center

Concho Valley Center for Human Advancement

El Paso Center for MHMR Services

Gulf Bend MHMR Center

Gulf Coast Regional MHMR Center

MHMR Authority of Harris County

Lubbock Regional MHMR Center

Navarro County MHMR Center

Northeast Texas MHMR Center

MHMR of Southeast Texas

Tarrant County MHMR Services

Wichita Falls Community MHMR Center

*Prepared by Community Services, TDMHMR
July 1, 1980

TABLE 2

COMMUNITY MHMR CENTERS FUNDED BY FEDERAL STAFFING GRANTS IN FY 1980*

Participating CMHC	Type of Federal Grants (Staffing, P.L. 94-63-Operations, Conversion, Distress, or Other)	% of Participation		Years Left	Date of Expiration
		Federal	Center		
Austin-Travis	NIMH Staffing	30%	70%	1.25	8/31/81
	NIMH Staffing	30%	70%	.25	8/31/80
	NIDA Staffing	40%	60%	.25	8/31/80
	NIAAA Staffing	30%	70%	1.33	9/30/81
Bexar County	NIAAA Staffing	70%	30%	2.00	5/31/82
	NIMH Operations	30%	70%	.25	8/31/80
	NIMH Operations	40%	60%	1.42	10/31/81
Brazos Valley	NIDA Staffing	57%	43%	-0-	6/30/80
Central Counties	NIMH Operations	70%	30%	4.25	8/31/84
	NIMH Staffing	30%	70%	1.33	9/30/81
	NIAAA Staffing	100%	0%	-0-	3/31/80
Central Texas	NIMH Operations	40%	60%	4.25	8/31/84
Dallas	NIMH Staffing	25%	75%	1.60	1/31/82
	NIMH Staffing	25%	75%	.25	8/31/80
	NIAAA Staffing	100%	0%	.25	8/31/80
	NIMH Community Support Program	100%	0%	.25	8/31/80
Deep East Texas	NIMH Operations	70%	30%	4.25	8/31/84
East Texas	NIMH Staffing	70%	30%	.25	8/31/80
	NIMH Staffing	70%	30%	2.25	8/31/82
	NIMH Conversion	70%	30%	.25	8/31/80
	NIMH Consultation and Education	Variable Formula-also includes \$0.25 per capita & amount of funds generated for this program of services		.25	8/31/80
Heart of Texas	NIMH Operations	80%	20%	5.33	9/30/85
North Central	NIMH Operations	80%	20%	8.00	5/31/88
Nueces	NIMH Staffing	30%	70%	2.25	8/31/82
	NIMH Staffing	30%	70%	2.25	8/31/82
Pecan Valley	NIMH Operations	90%	10%	7.75	2/28/88
Permian Basin	NIMH Operations	25%	75%	-0-	2/28/80
	NIMH Operations	30%	70%	2.00	6/30/82
Sabine Valley	NIMH Operations	70%	30%	4.33	9/30/84
Texoma	NIMH Operations	80%	20%	5.25	8/31/85
Tropical Texas	NIMH Staffing	70%	30%	1.50	12/31/81
	NIMH Staffing	70%	30%	2.25	8/31/82

*Prepared by Community Services, TDMHMR
July 1, 1980

CMHC MONOGRAPH SERIES NOW AVAILABLE

The MHRP is pleased to announce the availability of three recently produced publications. Each monograph in this series explores a distinct topic area critical to understanding community mental health in Texas, and its relationship to the Mexican American population. The monographs cover as comprehensively as possible the current budget allocation process used for the community mental health centers (CMHCs), the location of the CMHCs in relation to the state's Mexican American population, and the literature on the paradoxical underutilization of mental health services by Mexican Americans. In order to provide a brief overview of the contents of these publications, the following abstracts are provided. For further information on obtaining copies, contact: David Ramirez, Project Director, MHRP, Intercultural Development Research Association, 5835 Callaghan Rd., Suite 350, San Antonio, Texas 78228.

A Review of the Literature on the Underutilization of Mental Health Services by Mexican Americans: Implications for Future Research and Service Delivery by David G. Ramirez

Abstract

The review presents the research findings and issues which have been generated around the topic of Mexican American underutilization of mental health services. The discussion is divided into five major sections: 1) the presentation of the primary issue - the epidemiological paradox of Mexican American underutilization of services, 2) the explanations offered in the literature for the paradox, 3) an elaboration of the incompatibilities of services explanation, 4) an examination of the conceptual problems involved in underutilization, and 5) a discussion of the recommendations for change offered in the literature.

Four general conclusions were reached by the author. First, the underutilization phenomenon is not a homogeneous finding in the literature, and in some cases, overutilization is found. This is particularly evident in centers where an attempt has been made to provide compatible services to Mexican American clients. Second, the concept of utilization is quite complex, and in the absence of measures of need, accessibility and quality of services, it becomes difficult to interpret utilization rate findings. Third, among the diverse explanations offered for the underutilization paradox, it appears the concept of the existence of incompatibilities between the service delivery system and the characteristics of the clients holds the most conceptual promise. Finally, a two-tier approach is

suggested as the focus of future advocacy efforts in the area of the improvement of mental health services for Mexican Americans. This approach emphasizes both the concept of equity (equal accessibility and availability of services) and the concept of compatibility between the clients' needs and the services provided (the provision of appropriate and acceptable services). (\$6.00 per copy)

The Location of Community Mental Health Centers in Texas: Some Descriptions and Comparisons by Ramiro Valdez, Ph.D.

Abstract

An explanation often offered as a possible contribution to the underutilization of mental health services by Mexican Americans is the inaccessibility of many centers to the Mexican American population in need. The objective of this monograph was to conduct preliminary inquiries into the location of the community mental health centers in Texas and their accessibility with regard to the Mexican American population.

The procedure for the study consisted of mapping the location of the various CMHCs in relation to the major population groups found in the state. A subsequent analysis of five major metropolitan areas in Texas mapped the concentration of Mexican Americans by census tracts and again analyzed the location of the centers. The availability of public transportation and highways was also examined in the analysis.

The findings of this study indicated that the populations of the state of Texas cluster in the northeast portion of the state with the exception of the population belt along Interstate 35. There are a few other population clusters in the lower Rio Grande Valley, the Houston bay area, and El Paso. These combinations of clusters envelope virtually all the population of Texas. The Mexican American population is included in some of these latter clusters; however, the majority of the Mexican American population is in the southwestern part of the state.

Overall, it was concluded that the CMHCs are located primarily in the northeastern part of the state, while the Mexican American population is located in the southwestern part.

A conclusion drawn from the study indicates that Mexican Americans have poor access to services across the state, and that of five major metropolitan areas, four appear to provide access to the Mexican American community. The word "appear" is used because already this research has prompted some individual studies among residents in each of these five cities, and reports indicate that the maps and census tract figures

cont. next pg.

may be misleading to the extent that archival research would indicate accessibility while experience would indicate otherwise. Thus, in the future, we may find that not only is accessibility poor across the state, but in most of the major cities as well.

In some areas there is accessibility, but services may be less than desired; in others there may be better services but these are not accessible. (\$8.25 per copy)

Budget Allocation for Community Mental Health Centers in Texas: Process and Reality Implications for Mexican Americans

by Bernadette A. Brusco

Abstract

A description of the federal and state laws and their historical evolution germane to the funding of community mental health centers is provided.

The appropriation process that Texas follows for its biennial budget is explained, with emphasis placed on the role of community mental health centers within this process. In addition, the sources of funds and the

various methods of securing these funds are described.

An exploration of the grant-in-aid process employed by the Texas Department of Mental Health Mental Retardation (TDMHMR) indicates that no policy currently exists in the funding criteria that specifically addresses the mental health needs of Mexican Americans, the state's largest linguistic minority group. Information is presented which documents the evolving policy surrounding the grant-in-aid, and the current effort which TDMHMR is putting forth in reformulating this policy as of May 1980.

The relationship between the amount of a center's grant-in-aid and the Spanish Language/Spanish Surname population in the center's catchment area is explored. The paper also examines the relationship between the grant-in-aid and the ethnic content of the centers' programs for fiscal year 1980, as presented in the centers' planning and budget documents. Findings indicate that there is no direct relationship. The study provides the basis for additional research into the relationship between the levels of funding of CMHCs and the Mexican American population. (\$9.00 per copy)

A PSYCHIATRIC PROGRAM FOR THE HISPANIC INPATIENT

*by Daniel L. Dolgin, Ph.D.
and*

Albertino A. Salazar, A.C.S.W.

The relevancy of human service programs for minorities (particularly Hispanics in the Southwest) has received increasing attention in recent years. It has been proposed (Padilla, Ruiz and Alvarez, 1975; Torrey, 1972) that traditional psychiatric treatment is essentially irrelevant to the Hispanic client. The predominant use of psychotherapeutic orientation as applied to lower social classes, culture-specific therapist values, and patient attitudes toward treatment have been associated with ineffective treatment of the Hispanic patient.

Areas of major concern that have been identified in the literature include not only the lack of availability of mental health services, but the need for basic changes or revisions of the traditional forms of psychiatric treatment so that more effective and appropriate treatment can be provided to the Hispanic patient (Phillipus, 1971; Kline, 1969). Some basic work in the development of specific therapeutic techniques for this

ethnic group have been reported in the literature (Boulette, 1975).

In an effort to correct the failures of the current psychiatric approaches, some attempts have been made through the development of specialized programs. Whatever success these programs may have had remain virtually unknown.

The present study assessed differences between a traditional psychiatric unit and a culture-specific experimental unit. There are key differences between the control and experimental units. The control (traditional psychiatric treatment) unit consists of traditional elements including chemotherapy when indicated, development of adaptive skills, recreational therapy, traditional GED, literacy and college preparatory education programs, along with individual and group psychotherapies in a traditional milieu setting. Aftercare programs are also utilized. The staff is predominantly Anglo and monolingual. In contrast, the experimental (Hispanic) unit offers a bilingual staff, culturally oriented treatment modalities, greater familial involvement, and more emphasis on ethnic identity and pride. Individual and group psychotherapies were modified with a cultural approach. Specifically, this entails folk remedies, budgeting, preparation of cultural foods, folk music and dance, language and cultural heritage classes. The

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Program

cont. from pg. 9

aftercare program requires much more familial involvement than the traditional psychiatric program.

The present investigation has resulted in the identification of significantly different responses to treatment dependent upon treatment modality.

Method

Three types of data were collected on forty-two Hispanic patients entering the Colorado State Hospital: data contained on State of Colorado Client Admission Forms PES 7A/7B and the Client Termination Form PES 10. The 7A Form is completed upon admission and contains demographic information pertaining to the client. The 7B Admission Form is identical to the PES 10 Termination Form with the difference being that the 7B Admission Form is completed for a given patient upon admission whereas the PES 10 Termination Form is completed when a patient terminates treatment. Client Admission and Client Termination Forms are divided into nine categories which indicate the level of functioning in a given area. Each variable is scored from one to fifty with the higher numbers indicating greater dysfunction.

Hispanic patients entering the hospital were randomly assigned to the Hispanic Treatment Unit (experimental) or the traditional psychiatric unit (control). Thus, groups (experimental and control units) were comprised of twenty-one patients per group. The statistical analyses were based on patients admitted and discharged from treatment within a four-month period.

Results and Discussion

Table 1 (pg. 11) shows the means and 2-tailed t values for each of the groups on the 9 admission level of functioning (ALOF) categories. Of the nine ALOF categories, there was no statistically significant difference between groups on Substance Abuse, Medical-Physical Health, Education, or Meeting Basic Needs ratings. Experimental unit patients showed significantly greater dysfunction upon admission for mental processes, $t=2.67$, $df=40$, Emotional Health, $t=2.85$, $df=40$, Personal Behavior, $t=2.01$, $df=40$, and Interpersonal Relationship ratings, $t=2.02$, $df=40$. These significant comparisons show that experimental unit patients were functioning at a lower level upon admission relative to control unit patients entering treatment. Socio-Legal Functioning was the only category in which greater dysfunction was found for control unit patients upon admission, $t=2.02$, $df=40$. The combined ALOF scales did not produce meaningful differences between the groups. The failure to obtain significant differences on the ALOF summary supports the adequacy of the random assignment procedure.

Table 2 (pg. 11) shows the means and 2-tailed post-level t values for each of the groups on the 9 termination level of functioning (TLOF) categories. Patients receiving treatment in the experimental unit showed significantly greater improvement across 8 of the 9 levels of functioning categories upon discharge compared to control unit patients. In category 1 (Socio-Legal Functioning) improvement was almost identical for the 2 groups. The only category not exceeding the .01 confidence level or greater was the Medical Physical Health rating, $t=2.12$, $df=40$, significant at the .05 confidence level. The termination level of functioning summary of the nine scales, $t=5.63$, $df=40$, was significant at the .001 confidence level indicating that the experimental unit produced superior treatment outcome results relative to the traditional psychiatric program with Hispanic patients. The more prominent ALOF for experimental unit patients on the four level of functioning categories in conjunction with the comparable ALOF summary supports the contention that patients assigned to the experimental unit experienced a greater degree of improvement than did patients receiving treatment on the control unit. These findings suggest that Hispanic patients showed greater responsivity to treatment on the experimental unit relative to the control unit.

The findings from the present investigation confirm that Hispanic patients in a hospital setting display different rates of improvement depending on the treatment modality being implemented, i.e., Hispanic Treatment Program versus traditional psychiatric treatment. The question of major interest now becomes one of how these differences in mode of treatment come to bear on the background, self-concept, acculturation and cognition of the Hispanic.

This study was conducted at the Colorado State Hospital and is part of a program funded by the National Institute of Mental Health (Grant No. MH29016-02).

References

- Boulette, T.R., Group Therapy with low-income Mexican-Americans. *Social Work*, 20 (5) 403-405, 1975.
- Kline, L. Some Factors in the Psychiatric Treatment of Spanish-Americans. *American Journal of Psychiatry*, 1969, 125 (12), 1674-81.
- Padilla, A.M., Ruiz, P.A., and Alvarez, R. Community Mental Health Services for the Spanish-Speaking Surname Population. *American Journal of Public Health*. Vol. 61, (4), April, 1971.
- Torrey, E.F., *The Mind Game: Witch-Doctors and Psychiatrists*, New York: Emerson Hall, 1972.

TABLE 1. ALOF FOR EXPERIMENTAL AND CONTROL UNITS.

T-Tests - Comparisons of Experimental Versus Control Groups

GROUP 1 - Experimental Unit
GROUP 2 - Control Unit

	Number of Cases	Mean	t value
ALOF1 GROUP 1 GROUP 2	SOCIO-LEGAL FUNCTIONING RATING ADM 21 21	23.9048 30.1429	-2.02
ALOF2 GROUP 1 GROUP 2	SUBSTANCE ABUSE RATING ADM 21 21	23.9048 27.8095	-1.00
ALOF3 GROUP 1 GROUP 2	MEDICAL PHYSICAL HEALTH RATING ADM 21 21	16.0952 20.1429	-1.41
ALOF4 GROUP 1 GROUP 2	MENTAL PROCESSES RATING ADM 21 21	35.0476 27.7619	2.67
ALOF5 GROUP 1 GROUP 2	EMOTIONAL HEALTH RATING ADM 21 21	39.4762 30.9524	2.85
ALOF6 GROUP 1 GROUP 2	PERSONAL BEHAVIOR RATING ADM 21 21	37.5714 31.6190	2.01
ALOF7 GROUP 1 GROUP 2	INTER PERSONAL RELATIONSHIPS RATING ADM 21 21	37.7619 30.7143	2.50
ALOF8 GROUP 1 GROUP 2	EDUCATION RATING ADM 21 21	27.6190 30.3810	-0.86
ALOF9 GROUP 1 GROUP 2	MEETING BASIC NEEDS RATING ADM 21 21	24.8571 26.7143	-0.61
ALOF SUM GROUP 1 GROUP 2	SUM OF 9 LOF SCALES ADM 21 21	266.2381 256.2381	0.471

TABLE 2. TLOF FOR EXPERIMENTAL AND CONTROL UNITS.

T-Tests - Comparison of Experimental Versus Control Groups*

GROUP 1 - Experimental Unit
GROUP 2 - Control Unit

	Number of Cases	Mean	t value
TLOF1 GROUP 1 GROUP 2	SOCIO-LEGAL FUNCTIONING RATING TERM 21 21	15.4762 21.6190	-3.14
TLOF2 GROUP 1 GROUP 2	SUBSTANCE ABUSE RATING TERM 21 21	16.1905 27.5238	-4.27
TLOF3 GROUP 1 GROUP 2	MEDICAL PHYSICAL HEALTH RATING TERM 21 21	15.9524 19.5714	-2.12
TLOF4 GROUP 1 GROUP 2	MENTAL PROCESSES RATING TERM 21 21	15.5238 21.4762	-3.99
TLOF5 GROUP 1 GROUP 2	EMOTIONAL HEALTH RATING TERM 21 21	16.1905 21.4286	-3.91
TLOF6 GROUP 1 GROUP 2	PERSONAL BEHAVIOR RATING TERM 21 21	15.7143 22.7619	-3.62
TLOF7 GROUP 1 GROUP 2	INTER PERSONAL RELATIONSHIPS RATING TERM 21 21	17.6190 25.4762	-3.36
TLOF8 GROUP 1 GROUP 2	EDUCATION RATING TERM 21 21	15.0000 24.6667	-5.11
TLOF9 GROUP 1 GROUP 2	MEETING BASIC NEEDS RATING TERM 21 21	15.0000 21.9083	-3.36
TLOF SUM GROUP 1 GROUP 2	SUM OF 9 LOF SCALES TERM 21 21	142.6667 205.6190	-5.63

*t tests performed on change scores

Literature Review

by Sharon Sepúlveda Hassell

CROSSING CULTURES IN THERAPY: PLURALISTIC COUNSELING FOR THE HISPANIC

Elaine S. LeVine and Amado M. Padilla
(Monterey, CA: Brooks/Cole Publishing Co., 1980)

Crossing Cultures in Therapy offers mental health treatment providers, program administrators, social science researchers and students a concise, yet comprehensive, presentation of the multiple cultural dynamics related to the counseling experience involving the Hispanic client. Through the authors' presentation of the pluralistic therapy paradigm, the reader is introduced to the essential components of bilingual and bicultural service delivery as well as the sociological and cultural experiences of Hispanic populations within the United States.

The authors' development of the pluralistic therapy paradigm, which emphasizes the bilingual and bicultural aspects of service delivery to Hispanics, is rooted in the recognition of cultural diversity and cultural integrity. Throughout the book, LeVine and Padilla restate the importance of facilitating the client's functional adaptation to the cultural milieu of his choice. The pluralistic therapy model calls for the service deliverer to be aware of the points of contact and conflict between ethnic minority and majority groups. Of particular importance is the recognition of institutionalized forms of racism and oppression that undermine the mental and emotional well-being of

Hispanics and negatively influence their responsiveness to traditional mental health services. A social advocacy orientation is discussed as an important component of the culturally sensitive, pluralistic therapist's functions.

The diagnostic and treatment methods promoted by LeVine and Padilla are sensitive to culturally-sanctioned norms of illness and health. The role of other important cultural variables (such as the role of the family, reference to folk illnesses and treatment, emphasis on religion, and nature of the client's symptomatology) within the treatment process is also discussed by the authors. Rather than adhering to a specific treatment modality, the culturally-sensitive pluralistic model recommends the selection of a modality based upon the client's needs and goals. Flexible interventions structured around the client's needs rather than the traditional 50-minute therapeutic hour are considered instrumental to effective cross-cultural services. This, however, necessitates a supportive institutional context that recognizes the necessity for and significance of culturally-sensitive procedures.

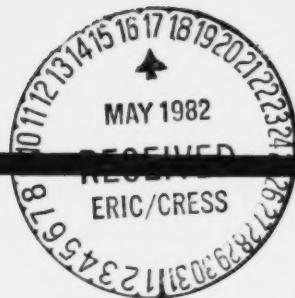
The pluralistic therapeutic model has several attributes that maximize its applicability to large numbers of Mexican American service recipients. It recognizes the heterogeneous nature of cultural lifestyles found among Hispanics and ascribes no qualitative values to either traditional or acculturated cultural adaptations. The needs of the client are the primary concern, whether these are for tangible economic assistance or for introspective psychotherapy. Overall, the pluralistic bilingual-bicultural model presented in *Crossing Cultures in Therapy* has considerable potential applicability to service deliverers and mental health administrators committed to meeting the mental health needs of Mexican Americans in Texas.



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NEWSLETTER OF THE MENTAL
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Vol. 2 No. 4

COMMUNITY MENTAL HEALTH CENTERS: THEIR RESPONSIBILITIES TO MEXICAN AMERICAN CHILDREN AND OTHER UNDERSERVED YOUTH

by David Ramirez and Sharon Sepúlveda Hassell, A.C.S.W.

The range of comprehensive services to be offered by community mental health centers (CMHCs), as outlined by PL 94-63, includes children's mental health services as one of the twelve essential service components. This federal mandate undoubtedly flows from the long history of concern for the health needs and general well-being of children in the United States, which is evidenced by the repeated occurrence of White House Conferences on Children at approximately 10-year intervals over the last 70 years. Despite the on-going avowed interest in the welfare of children, many federally funded health care delivery programs have failed to reach children, particularly low-income minority children who are generally in need of the greatest ameliorative and preventive health services. The Medicaid Early and Periodic Screening Diagnosis and Treatment (EPSDT) program, for example, was enacted in 1967 to provide poor children such services via a comprehensive screening, identification of need (which could involve mental health needs) and treatment services network. EPSDT, however, has touched only a fraction of the children to be served nationally, as only about 25 percent of all eligible children are screened, and only half of the problems disclosed during screening are ever treated (Rosenbaum, 1980). Despite the federal intent and available funds, the conceptualized network of health care for poor children is yet to be fully realized.

A nationwide survey of community mental health centers' services for children corroborates the failure of federally endorsed and funded mental health care to reach children in need of services. Glasscote, Fishman and Sonis' national survey (1972) of CMHC children's services indicated only a few CMHCs where children's services were given priority, and none where comprehensive children's services were in effect. The President's Commission on Mental Health justifiably designated children as an underserved population with respect to mental health services and called for an increased commitment of resources to serve the neglected population of children and youth (Report of the Sub-Task Panel on Infants, Children and Adolescents, 1978).

In light of the reported failures of health and mental health services to reach the targeted population of children, it is unlikely that the mental health risks and problems faced by Mexican American children have been sufficiently understood or adequately addressed by the community mental health system. Mexican American children are at-risk with regard to mental and emotional disturbances for a number of reasons. The social and economic factors that contribute to the vulnerability of Mexican American children, as well as the delivery of community mental health services by Texas CMHCs to this minority cohort, will be discussed in this article.

The Status of Mexican American Children and Youth.

Of the sixty-four million children under the age of 18 in the United States, approximately 11.2 percent are of Hispanic origin (Ramirez, 1979). Hispanics are the youngest of all ethnic populations in the country, having a median age of 20.7 years compared to 28.6 years for the general population. For Mexican Americans, the median age is slightly lower at 20.3 years. Overall, Hispanic children and youth constitute the minority group with the largest proportion of children in the country, as 44 percent of the Hispanic population is under 18 years compared to 31 percent for the general population (Florez, 1978). The predominance of the Mexican American population in the younger age groups is evident in population data for Texas community mental health center service areas as noted in Table 1 (percentage figures based on projected population sizes for 1978). Table 1 depicts the percentage of individuals who are 20 years of age or under in each ethnic population by service area. As is apparent, there is clearly an overrepresentation of Mexican Americans in the 20 and under age group.

The Report to the President of the United States National Commission on the International Year of the Child (1980) indicates that the greatest obstacle faced by Mexican American and other minority children is the poverty of their families. The social and economic environment in which the child is reared is considered to be the most important predictor of later overall well-being in terms of health, education, employment, and

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wage earning potential (Calhoun, Grotberg & Rackley, 1980). Mental health experts suggest that children of poverty are at a particularly high risk for mental health problems. Mexican American children and youth are overrepresented among the poverty population in the nation and, as such, experience higher morbidity and mortality rates, a greater likelihood of being raised in a one-parent, female-headed family, as well as higher rates of school failure, runaway, substance abuse, unemployment and underemployment (Florez, 1978). Census estimates of the population living below the poverty level indicate that 29 percent of Spanish-origin children in all types of families and 69 percent of Spanish-origin children in female-headed families exist within poverty conditions (Calhoun, Grotberg & Rackley, 1980). Social service providers often comment that their field experience suggests that the Census figures are low, which may be a reflection of methodological limitations of Census data collection procedures. Data on admission to outpatient mental health facilities show an admission rate four times greater for children of female-headed families than husband-wife families. The influence of poverty is no doubt significant, as the female-headed families have median incomes less than half those of two-parent families (Calhoun, Grotberg & Rackley, 1980).

Due to the significant numbers of Mexican Americans and the poverty status of many in this population, it is astonishing that Mexican American and other Hispanic children and youth have been the focus of very little federal or state concern in data collection efforts or the delivery of health and mental health services. The failure of the original Joint Commission on Mental Illness and Health to address the mental health status of children and the subsequent efforts of the Joint Commission on Mental Health of Children to assess the mental health status of American children did not illuminate the causes for the "innate resistance to helping children that glows in the sub-basement of our national consciousness" and the lack of commitment and attention to the mental health care of children (Group for the Advancement of Psychiatry, 1972, p. 113). The pro-child rhetoric that has surfaced during recent years is in sharp contrast to the previous resistance on the part of government and mental health providers to address the needs of the large, but not politically or socioeconomically powerful, population of children.

The status of services to Mexican American and other poor minority children is even more lamentable, as these children experience the same pervasive social and economic inequalities encountered by the larger poverty and minority populations, but are even less able to articulate or convey their mental health and social support needs. As noted in *Crisis in Child Mental Health: Challenge for the 1970's*:

The mental health problems of our nation's minority-group children are intricately interwoven with socioeconomic factors. The high rate of poverty or near-poverty among minority people means that minority children are at high risk in areas of nutritional, physical, and psychological health. Racist attitudes and practices are reflected in all areas of living. Among children, racism often contributes to impaired self-images, a high incidence of "educational retardation," alienation and isolation, and high rates of youth unemployment and underemployment. (Report of the Joint Commission on Mental Health of Children, 1980, p. 244)

The *Report of the Joint Commission on Mental Health of Children* indicates that the mental health of the Mexican American child and other minority children can be seriously impaired during this important developmental period by the negative, racist response of the dominant society to the child's ethnic identity. According to the Report, "The result for many minority-group children is a loss of cultural identity and/or ambivalence toward the life styles of their family or group. They become caught between two worlds, not quite belonging to either" (*Report of the Joint Commission on Mental Health of Children*, 1970, p. 227). The Anglo/White educational system that resists recognizing the language and cultural differences of minority students precipitates cultural alienation and a stressful identity struggle for the child who daily encounters the points of contact and conflict between the school and home environments. The *Report to the President* by the United States National Commission on the International Year of the Child noted that, "a pervasive lack of recognition and respect for cultural and language diversity destroys children's sense of identity and acceptance" (United States National Commission on the International year of the Child, 1980, p. 71).

Many obstacles are encountered by Mexican American children in the educational and social system. For example, the misdiagnosis of Hispanic children results in up to ten times the rate of minimal brain dysfunction as is found in the general population (Report of the Special Populations Sub-Task Panel on Mental Health of Hispanic Americans, 1978). Although nearly 174,000

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emotionally and mentally handicapped Hispanic children were estimated to be in need of services by the Office of Civil Rights Elementary and Secondary School Survey of 1978-1979, there is critical lack of bilingual/bicultural individuals equipped to assess, evaluate and teach the Hispanic handicapped child (Gavillan-Torres, 1980). Mexican American and other minority children are institutionalized in medical and educational facilities at a rate twenty percent higher than Whites, and are institutionalized in correctional facilities at a rate four times that of White children (Calhoun, Grotberg & Rackley, 1980).

Mexican American youth are exposed to numerous mental health stresses due to the developmental difficulties characteristic of adolescence and young adulthood, and, in addition, due to their socioeconomic vulnerability to the non-supportive nature of educational, employment and correctional service systems. Although the National Council of Organizations for Children and Youth expects the incidence of juvenile delinquency to rise for all youth in the 1980s, the expected increase will particularly affect Mexican American youth due to the anticipated increases in youth crimes in urban areas (where 81 percent of the

Mexican American population reside) and the anticipated increases in youth crime by all racial and ethnic minority youth (Florez, 1978). The treatment of juvenile offenses shows considerable ethnic and racial variation. Minorities are more likely to be charged with crimes against people (16.3 percent of all cases involving minorities compared to 6.4 percent for cases with Whites). The legal proceedings involving minority youth are also processed more slowly (49.2 percent of cases are processed within one month) than for Whites (59 percent of cases are processed within one month) (Calhoun, Grotberg & Rackley, 1980).

The prevalence of youth crime is undoubtedly linked to the poverty status of the majority of Hispanic youth. Frequently, this condition of poverty cannot be improved despite the efforts of minority youth due to the high rates of unemployment and underemployment experienced by Mexican American and other minority youth. The unemployment rate for Hispanic youth was 19.1 percent in 1979 (Calhoun, Grotberg & Rackley, 1980). Hispanic young women experience a disproportionate share of the unemployment problems (The Vice President's Task

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TABLE 1
PERCENTAGE OF INDIVIDUALS 20 YEARS OF AGE
OR LESS BY CENTER SERVICE AREA

CENTER	ANG	MEX A	BLK
ABILENE REGIONAL MHMR CENTER	35.2	55.2	48.9
AMARILLO MHMR REGIONAL CENTER	35.9	56.1	47.5
MHMR CENTER-AUSTIN-TRAVIS COUNTY	37.8	51.6	45.8
BEXAR COUNTY MHMR CENTER	37.6	51.9	46.4
BRAZOS VALLEY MHMR CENTER	35.5	53.8	45.8
CENTRAL COUNTIES CENTER FOR MHMR SERVICES	33.6	48.8	42.1
CENTRAL PLAINS COMPREHENSIVE CMHMR CENTER	34.4	61.5	57.1
CENTRAL TEXAS MHMR CENTER	27.6	55.1	47.5
DALLAS COUNTY MHMR	38.9	53.2	50.2
DEEP EAST TEXAS REGIONAL MHMR SERVICES	36.1	42.5	47.9
MHMR REGIONAL CENTER OF EAST TEXAS	33.8	51.3	46.7
EL PASO CENTER FOR MHMR SERVICES	39.2	53.3	50.2
CONCHO VALLEY CENTER FOR HUMAN ADVANCEMENT	34.9	52.5	41.8
GULF BEND MHMR CENTER	34.9	52.9	41.5
GULF COAST REGIONAL MHMR CENTER	39.1	51.9	45.3
MHMR AUTHORITY OF HARRIS COUNTY	39.2	53.0	48.7
HEART OF TEXAS REGION MHMR CENTER	32.1	53.1	44.5
LUBBOCK REGIONAL MHMR CENTER	38.2	59.5	54.0
NORTHEAST TEXAS MHMR CENTER	33.7	48.2	46.3
NUECES COUNTY MHMR COMMUNITY CENTER	36.1	51.5	43.7
PECAN VALLEY MHMR REGION	35.7	53.2	45.1
PERMIAN BASIN COMMUNITY CENTERS FOR MH AND MR	40.0	57.7	50.3
SABINE VALLEY REGIONAL MHMR CENTER	33.8	46.9	43.5
MHMR OF SOUTHEAST TEXAS	38.7	49.0	47.8
TEXOMA REGIONAL MHMR CENTER	35.6	53.7	47.6
TARRANT COUNTY COMMUNITY MHMR CENTER	39.3	53.3	49.0
TROPICAL TEXAS CENTER FOR MHMR	27.5	54.3	43.9
WICHITA FALLS COMMUNITY MHMR CENTER	39.0	52.5	48.2

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Force on Youth Employment, 1980). The employment problems faced by Hispanic youth are compounded by the fact that at least one third of young adults of Hispanic origin do not complete high school (Calhoun, Grotberg & Rackley, 1980).

Because of the youthful composition of their population, Mexican American families are especially concerned about the vulnerability of their young people to substance abuse. Findings from the Spanish Speaking Mental Health Research Center document the magnitude of the problem in one major metropolitan area (Padilla et al., 1977). Compared to a 1975-1976 national survey, Mexican American adolescents were at least 14 times more likely to be currently abusing inhalants, and the prevalence rate of marijuana use was double the national rate, while the prevalence of alcohol consumption was equal to that found nationally and characterized as an epidemic. A follow-up survey two years later (Perez et al., 1979) documents that the use of inhalants had declined markedly, apparently due to the intervention of a local educational effort. The use of alcohol and marijuana, however, had increased across all age and sex cohorts, and new data exploring the use of the drug PCP show extremely high prevalence.

The Extent of Mental Illness Among Minority Children

Despite the high risk of mental health difficulties faced by Mexican American and other minority children and youth, little research is available to delineate the magnitude of the prevalence of mental health problems in this group. Nevertheless, the research that is available presents some alarming conclusions. For example, previous epidemiological studies have found that childhood emotional disorders in inner city and urban areas, where the great majority of Mexican American children reside, are more prevalent than in rural settings (Rutter, Cox, Tupling, Berger & Yule, 1975). In addition, the data of Langner, Gersten and Eisenberg (1974) indicated that proportionately about twice as many Black and Spanish-speaking children as non-Spanish-speaking children residing in an inner city show signs of severe psychiatric disorder. Finally, Kellam, Ensminger and Turner (1977) found the rate of disorder in children to vary as a function of family structure. Kellam et al. found mother-alone families had the highest risk of maladjustment in children, and mother-and-father families the lowest risk. Taken together, each of the above findings point to a higher prevalence of mental health difficulties in Mexican American children. Coupled with the general finding of a higher prevalence of mental illness in lower socioeconomic status (SES) groups (Dohrenwend, Dohrenwend, Gould, Link, Neugebauer & Wunsch-Hitzig, 1980) and the overrepresentation of Mexican Americans in lower SES groups, one would expect a significantly higher prevalence of mental illness in Mexican Americans and their children. Dohrenwend et al. (1980) reported that in an analysis of the majority of

epidemiological studies in the United States, "psychopathology" in general was found to be at least two and a half times more prevalent in the lowest class than in the highest class.

This same review led the authors to conclude:

that the true prevalence of clinical maladaptation among school children in a representative sample of U.S. communities is unlikely to average less than 12 percent and is likely to vary according to age, social class, ethnic group, and geographic region. Studies providing the relevant information indicate that the large majority of these maladjusted children were not receiving treatment. (Dohrenwend et al. 1980, p. 150)

Using the Dohrenwend et al. (1980) conservative average figure of 12 percent as a base, one can speculate as to the magnitude of the higher rate of prevalence of disorder among Mexican American children. Given findings such as those discussed earlier by Langner et al. (1980) which indicated nearly twice as much psychiatric disorder among Spanish-speaking children, a prevalence figure of 24 percent for Mexican American children is possible. Irrespective of the actual magnitude of the prevalence rate for Mexican American children (about which we can only speculate without further research), it is clear that the prevalence rate for these children is higher, with the question now being only one of how much higher.

This conclusion is of particular importance with regard to the issue of treatment. Recalling the Dohrenwend et al. (1980) conclusion that "the large majority of these maladjusted children were not receiving treatment," an assessment of the treatment services delivered is warranted. Beyond the low rate of use of mental health services by children found nationwide, recent research by IDRA's Mental Health Research Project indicates an even lower rate of CMHC service use in Texas by Mexican American children in comparison to Anglo and Black children. A detailed discussion of this study follows.

An Analysis of the Utilization of CMHC Services by Mexican American Children and Youth

In order to examine the differential patterns of community mental health center (CMHC) service use across the variables of age, sex, ethnicity and geographic region, a series of utilization rates were generated in the following manner. Although 1978 CMHC utilization rates were determined for all age groups, only the age groups of birth-12 years and 13-20 years will be discussed. Population statistics from the 1970 Census for the number of Anglo, Black and Mexican Americans in Texas were obtained for each of the 28 CMHC service areas operational at the time of the study. Due to the lack of current population data and the need for accurate estimates of the number of persons in each age and ethnic group for the year 1978, it was necessary to generate a series of population projections. Through the use of two

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formulas discussed by Skyrock and Siegel (1976) and Census data for 1960, 1970 and 1975, population estimates were generated for the age and ethnic groups required. In this case, two age groups (birth-12 and 13-20) and three ethnic groups were analyzed (Anglo, Black and Mexican American).

The next step involved acquiring corresponding numbers of users of mental health services (narrowly defined excluding drug, alcoholism, mental retardation and individuals served without a diagnosis) which were served in any one of the 28 CMHCs in Texas during 1978. In addition, a comparable set of figures was obtained for those individuals who used any form of CMHC service exclusive of mental retardation services. With the users of services within each age and ethnic group forming the numerators and the corresponding population estimate for each group becoming the denominators, a set of rates of use per thousand was generated. These rates are shown in Table 2.

Two cautionary notes must be stated with regard to these figures. First, these rates are subject to considerable variation across centers due to a wide range of factors which are not controlled in this study, such as the type of service provided (centers with high use rates may be providing more services or providing service in a style that allows for a faster rate of client "processing") or the availability of alternative service providers (which is likely to affect the utilization rates in urban CMHC service areas).

Second, if one attempts to interpret any pair of utilization rates for two different age or ethnic groups by only comparing the differential numerical magnitude between the pair, one must assume equal rates of need for service in both groups. As the assumption of equivalent need for service across age and ethnic groups is in all probability faulty (Ramirez, 1980), one must be cautious in interpreting in isolation any two of the rates shown. For example, in comparing the Anglo and Mexican American children's (birth-12) utilization rates for Harris County MHMR (Houston area) of 1.3 per thousand and 1.2 per thousand respectively, one must be careful not to interpret these numbers too literally. As the epidemiological literature cited earlier indicated, urban Spanish-speaking children may have both a higher need for services and less access to alternative providers than their Anglo counterparts. The factor of differential need for services must be kept in mind when considering these rates.

What is far more important in the figures shown is the pattern found across centers. Utilizing the Kruskal-Wallis and Mann-Witney U non-parametric statistical tests, an examination of these patterns is possible. As can be noted in Table 2, in the six columns of utilization figures for children ages birth-12, a fairly consistent pattern of lower use by Mexican American children is clearly evident in both the mental health only and all services (excluding mental retardation) combined categories. Across centers and within ethnic groups, considerable variance in rates is expected, but the

Kruskal-Wallis and Mann-Witney U tests determine whether the difference between groups is larger than the variation within groups, or whether or not the difference shown is significant. Significance on the Kruskal-Wallis test will indicate that at least one of the three ethnic group rates are significantly different from any one of the other groups. The Mann-Witney U test will pinpoint where any differences really lie.

The following results were obtained using the data shown in Table 2. For the birth-12 year age groups in the mental health only breakdown (columns 1-3) the highest rate of use was exhibited by Blacks, followed by Anglos and, lastly, Mexican Americans. The Kruskal-Wallis test indicated a definite difference between these groups ($H = 13.6, p < .005$). In order to determine specifically which groups differed, a Mann-Witney U was run across the three combinations with the following results: 1) between the Anglo and Mexican American groups ($U = 223, p < .003$), indicating a significant difference with Mexican Americans using less than Anglos; 2) between the Mexican American and Black groups ($U = 293.5, p < .053$), indicating a relationship bordering on significance with Mexican Americans using less services than Blacks; and 3) between the Anglo and Black groups ($U = 302, p = .07$), indicating no significant difference between the Anglo and Black groups.

Still within the birth-12 age group, an analysis of the utilization rates for all services exclusive of mental retardation services (columns 4-6) was also conducted with the following results. Statistically significant differences between groups were indicated by the Kruskal-Wallis test ($H = 8.23, p < .025$). Again, Blacks were found to use services at higher rates, followed by Anglos and then Mexican Americans. Specifically, in comparing the groups: 1) Anglos used services at higher rates than Mexican Americans ($U = 217, p < .002$), 2) Blacks used services at a higher rate than Mexican Americans ($U = 278, p < .032$); and 3) again, no significant differences were found between the use of services by Blacks and Anglos ($U = 343, p = .21$). It should be noted that the correspondence of findings in both comparisons with the birth-12 age groups (i.e., mental health only and total services exclusive of mental retardation services) should not be surprising, as in this age group both comparisons are based on nearly the same rates. This is due to the non-representation of this age group in drug and alcoholism services. In comparison, the 13-20 age groups will be quite different in their rates as a number of youth utilize drug and alcoholism services.

The same form of analysis was run on the comparable figures for the 13-20 year age groups with very similar results (see Figures 1 and 2). Figure 1, which compares the use of mental health services by the 13-20 age groups, indicates the same pattern of results which were found in the birth-12 age comparisons. Mexican Americans used services at rates significantly lower than Anglos and Blacks. Nevertheless, as Figure 2 shows, the differences between groups is not as pronounced and hence is not

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significant statistically. The sum of the ranks does indicate, however, that the pattern described earlier is partially evident, as the Mexican American sum of ranks score is lower than the Black and Anglo scores, indicative of their lower rate of use. It must be reiterated that equivalence of rates is not synonymous with adequate use of services if there is differential need.

Both of the age groups described indicate results which are in support of a paradoxical finding, as Mexican American children and youth appear to use mental health services at a significantly lower rate than their Anglo and Black counterparts. This finding results despite their probable greater need for services, particularly in relation to Anglo children. The data appear to support the contention that Mexican American children and youth are not being adequately served by the existing CMHC system. Yet another point of interest is the overall magnitude of the numbers shown in Figure 2. Recalling that Dohrenwend et al. indicated that approximately 12 percent of children in the general population are psychiatrically impaired and that the rates shown in Figure 2 are rates per thousand, then numbers in the area of 120 would be expected (120 being 12% of 1000). Clearly, CMHCs are only one system of service providers in the larger mental health system and other systems also provide services to children. Nonetheless, in comparing the approximate 120 per thousand figure (expected to be in need) with the numbers shown in Figure 2, we must

question just how many of the children in need of service are being served.

Adapting CMHC Services to Reach Children

The preceding analysis of CMHC service utilization by Mexican American children represents a preliminary effort to determine the extent to which the federally mandated CMHC children's services are reaching the presumably at-risk population of Mexican American children. The causes of the predominant underutilization phenomena are undoubtedly varied and complex. A number of these factors will be briefly discussed with regard to how these could be altered to affect positively the delivery of community mental health services to Mexican American children, as well as other children in need of services.

The low utilization of Texas CMHC services by Mexican American and other children may be partially due to inadequacies in the identification of children in need of services. Seldom are all the children who are in need of services appropriately identified. While psychotic children and adolescents are generally known to at least one treatment facility, the research findings on the epidemiology of childhood mental disturbances suggest that the majority of clinically maladjusted children do not receive treatment. According to Langner (1974) and Graham and Rutter (1973), the more serious the

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Figure 1

Analysis of Rates for 13-20 Year Old Users of Mental Health Services (in the narrow sense excluding alcoholism, drug abuse and mental retardation services)

	ANGLO	MEXICAN AMERICAN	BLACK
Sum of Ranks	1381	995	1234

Kruskal-Wallis test borders on significant ($H = 5.62$, $p < .08$)

- U tests: 1) *Anglo-Mexican American* comparison ($U = 258$, $p < .014$) significant with Mexican Americans showing lower use than Anglos.
- 2) *Black-Mexican American* comparison ($U = 294.5$, $p < .055$) bordering on significance with Mexican Americans using less than Blacks.
- 3) *Anglo-Black* comparison ($U = 336.5$, $p < .182$) nonsignificant indicating no difference in use of services by Anglos and Blacks.

Note: Despite the lack of statistically significant differences between groups, it should be noted that the sum of ranks scores again point to a lower rate of use by Mexican Americans.

Figure 2

Analysis of Rates for 13-20 Year Old Users of Any CMHC Service with the Exception of Mental Retardation Services

	ANGLO	MEXICAN AMERICAN	BLACK
Sum of Ranks:	1313	1064	1193

Kruskal-Wallis test is nonsignificant ($H = 1.86$, $p < .25$)

- U tests: 1) *Anglo-Mexican American* comparison ($U = 317$, $p < .11$) nonsignificant difference.
- 2) *Black-Mexican American* comparison ($U = 341$, $p < .21$) nonsignificant difference.
- 3) *Anglo-Black* comparison ($U = 344$, $p < .22$) nonsignificant difference.

TABLE 2
UTILIZATION RATES PER 1000 BY
ETHNICITY, AGE AND SERVICE AREA

CENTER	AGES BIRTH - 12						AGES 13 - 20					
	MENTAL HEALTH ONLY			ALL SERVICES EXCLUDING MENTAL RETARDATION (INCLUDES MENTAL HEALTH)			MENTAL HEALTH ONLY			ALL SERVICES EXCLUDING MENTAL RETARDATION (INCLUDES MENTAL HEALTH)		
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
	ANG	MEX A	BLK	ANG	MEX A	BLK	ANG	MEX A	BLK	ANG	MEX A	BLK
ABILENE REGIONAL MHMR CENTER	2.0	1.0	1.6	2.3	1.2	2.1	5.2	2.9	2.2	10.8	12.5	6.0
AMARILLO MHMR REGIONAL CENTER	1.9	2.9	1.0	5.2	3.9	3.4	7.8	9.6	5.4	16.3	20.5	11.8
MHMR CENTER-AUSTIN-TRAVIS COUNTY	4.8	2.5	7.1	5.7	3.4	8.4	6.4	7.6	10.7	7.8	16.8	15.1
BEXAR COUNTY MHMR CENTER	1.5	2.4	3.1	3.2	4.9	7.9	2.4	6.1	5.3	4.9	12.4	9.9
BRAZOS VALLEY MHMR CENTER	3.2	1.1	1.9	5.3	2.6	3.1	5.9	3.5	2.6	10.7	9.4	8.8
CENTRAL COUNTIES CENTER FOR MHMR SERVICES	4.2	1.1	2.2	5.5	1.9	3.1	7.0	5.3	6.3	10.5	9.6	9.5
CENTRAL PLAINS COMPREHENSIVE CMHMR CENTER	7.4	6.2	13.5	9.5	8.7	16.5	14.8	9.8	10.0	17.4	13.5	12.5
CENTRAL TEXAS MHMR CENTER	3.5	1.7	0.0	6.0	4.3	0.0	7.7	2.4	15.8	11.8	3.0	25.7
DALLAS COUNTY MHMR	1.7	1.8	1.8	2.5	1.8	2.7	5.3	4.4	7.6	6.9	5.8	9.8
DEEP EAST TEXAS REGIONAL MHMR SERVICES	4.1	0.0	1.4	5.4	.9	2.2	9.2	6.9	7.1	11.8	9.9	9.1
MHMR REGIONAL CENTER OF EAST TEXAS	2.9	.9	1.4	3.6	1.8	2.7	7.0	1.4	3.5	8.4	1.4	4.8
EL PASO CENTER FOR MHMR SERVICES	5.7	4.5	5.1	6.3	5.3	6.8	4.9	5.2	4.3	5.6	5.7	5.7
CONCHO VALLEY CENTER FOR HUMAN ADVANCEMENT	2.8	2.1	6.3	4.9	4.7	6.3	7.6	6.7	14.7	10.3	9.2	13.6
GULF BEND MHMR CENTER	10.9	7.6	6.2	11.8	8.4	6.9	11.5	9.5	11.8	13.2	11.2	13.9
GULF COAST REGIONAL MHMR CENTER	1.9	1.0	1.5	2.3	1.3	2.1	3.1	2.0	4.4	3.6	2.7	3.2
MHMR AUTHORITY OF HARRIS COUNTY	.7	.3	.7	1.3	1.2	2.0	1.7	1.8	2.5	2.1	2.5	3.2
HEART OF TEXAS REGION MHMR CENTER	4.3	1.3	2.9	6.1	3.1	5.8	8.8	7.6	5.8	11.6	11.3	7.2
LUBBOCK REGIONAL MHMR CENTER	2.4	1.2	1.2	3.8	2.1	2.1	4.2	3.2	3.1	5.8	6.0	5.6
NORTHEAST TEXAS MHMR CENTER	5.0	0.0	2.7	6.7	0.0	5.2	10.0	16.6	5.4	13.5	22.1	9.4
NUECES COUNTY MHMR COMMUNITY CENTER	4.9	5.0	6.8	5.2	5.0	7.9	6.3	6.9	6.8	9.0	10.7	8.5
PECAN VALLEY MHMR REGION	3.2	1.9	0.0	3.5	1.9	0.0	12.1	0.0	3.2	12.8	0.0	3.8
PERMIAN BASIN COMMUNITY CENTERS FOR MH AND MR	8.6	5.1	8.5	9.6	5.8	9.4	15.0	13.6	18.1	16.9	17.1	19.2
SABINE VALLEY REGIONAL MHMR CENTER	4.1	0.0	1.0	5.1	0.0	1.7	8.4	0.0	4.3	10.2	0.0	6.0
MHMR OF SOUTHEAST TEXAS	2.0	.3	1.9	2.2	1.5	4.0	5.6	3.0	7.0	6.7	3.3	8.2
TEXOMA REGIONAL MHMR CENTER	3.1	3.3	3.7	4.8	5.0	5.9	7.8	1.8	5.1	9.9	3.5	8.2
TARRANT COUNTY COMMUNITY MHMR CENTER	.8	.4	1.0	1.4	.7	1.2	3.0	2.4	5.0	4.1	3.7	5.9
TROPICAL TEXAS CENTER FOR MHMR	2.6	1.3	6.3	4.0	1.9	6.3	5.0	2.6	6.3	8.9	5.0	9.5
WICHITA FALLS COMMUNITY MHMR CENTER	3.2	5.5	2.2	4.6	5.9	2.7	5.9	4.6	6.6	7.3	5.9	7.0
MEAN VALUES	3.69	2.20	3.32	4.92	3.18	4.59	7.13	5.27	6.82	9.6	8.35	9.45

CMHCs

cont. from pg. 6

disturbance, the more likely a child is to receive treatment. Regarding the factors that affect treatment, Dohrenwend concludes that:

Controlling for the child's level of impairment, other variables found to affect the likelihood of receiving treatment were the mother's level of education (Langner et al. 1974), the mother's mental health and the parent's tolerance of disturbed behavior (Mitchell & Shephard, 1966; Shephard, Oppenheim & Mitchell, 1971). The likelihood of treatment is greater the higher the mother's level of education, the poorer the mother's mental health, and the lower the tolerance of disturbed behavior. (Dohrenwend, 1980, p. 22)

In order to reduce the number of unidentified clinically maladjusted children in need of services, a closer collaboration between the CMHC and the social systems that deal primarily with children is recommended. High-impact social systems such as schools, child care providers, and public recreational programs (YMCA, YWCA, etc.) all deal intensively with children and consequently have a vitally important role to play in achieving a higher level of mental health care for Mexican American and other underserved children.

The Joint Commission on Mental Illness and Health (1961) emphasized the role schools play in the development of children and the need for primary prevention programs to be offered to school children (Berkowitz, 1968). The implementation of service programs at school facilities, such as structured activity groups for children with learning, behavioral or emotional problems, co-conducted by teachers and mental health care providers, would enable children whose parents do not recognize their problems or children who do not have access to transportation resources to participate more readily in preventive service programs. Because children's problems often reflect disturbances being experienced in the home, primary prevention efforts in the school could also identify families experiencing problems who might benefit from services but otherwise would remain unknown to the community mental health system. Strengthening a child's social skills and emotional and psychological resources could also positively affect his/her academic performance and development, which is generally believed to be influenced by a child's level of self-esteem. Other equally applicable primary prevention programs could be designed to incorporate the health care and recreational services utilized by children and their families.

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THE SOCIOPOLITICAL GENESIS OF CMHCs

by Alfonso Lopez-Vasquez, M.E.

The community mental health centers (CMHCs), which were idealistically described by the proponents of the Great Society as the keepers of the country's mental health, have survived despite recent evaluations that have termed CMHCs anywhere from dismal to outright failures (Sharfstein, 1977; Caplan, 1980; Owan, 1980). However, careful consideration must be given regarding the realistic chances for success which were provided the movement for community-based services, for it is possible that in the case of CMHCs, the expectations exceeded the means and the promises of CMHCs were larger than society's commitment. The rise and potential fall of the movement for community-based services have been documented and discussed by numerous authors (Chu & Trotter, 1979; Musto, 1975). What is of particular concern at this point is that the advocates of community mental health confront the fact that the sociopolitical environment that nurtured this movement may no longer exist. This article seeks to provide an overview of the sociopolitical genesis of the CMHCs, and propose the beginning of a dialogue on the issue of how the CMHCs will survive in the new ambience that must develop if the concept of community-based services is to continue.

The fundamental driving forces in the spectrum of social policy in the United States prior to the Great Depression possessed a common denominator — the assumption that if social situations are left alone, nature eventually will take its course and deal with these situa-

tions (Ferry, 1960). This mentality prevailed and dominated social policy up to the Great Depression but did not completely fade out after its end. It has continued to make its presence known throughout the struggle for civil rights and whenever the federal government has sought to promote the social welfare of historically neglected groups; one such example is the desegregation efforts in public schools (U.S. Commission on Civil Rights, 1975). The recent national elections evidenced a resurgence of advocacy for the "natural order" or Social Darwinism, as well as increased promotion for state and local control, and a sense of rebellion against the federal bureaucracy.

The programs, regulations and national policies that became part of the egalitarian movement and were intended to assist minorities, disadvantaged and handicapped populations may soon fall victim to the resurgence of the "natural order" of Social Darwinism and the pervasiveness of the free enterprise system unless provisions are made to protect the historically neglected. The future of the CMHC movement is also questionable, as its service mission may conflict with the philosophical orientation of the "natural order."

The "bold new approach" of community mental health proposed by President John F. Kennedy called for a "... move from the outmoded use of distant custodial institutions to the concept of community-centered agencies that would provide a coordinated range of timely

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diagnostic, health, educational, training, rehabilitation, welfare and legal protection services" (Kennedy, 1963). The delivery of these services for the mentally ill, as well as the program for prevention, were to be complemented by the general health, education, welfare and urban renewal programs that were to be part of President Kennedy's "New Frontier" and later, President Lyndon B. Johnson's "Great Society" programs.

The community-based mental health delivery system can be considered a culmination to a movement that has "... paralleled the enlightened concepts of the Nation itself..." which began with the crusade that was led by Dorothea Dix in the mid 1800s. The crusade was in pursuit of humane and moral treatment for the mentally ill by providing them care in asylums instead of confinement in jails and almshouses (NIMH, 1977). This noble idea received impetus from the civil rights movement that peaked in the 1960s. The community mental health centers and the goals and objectives of the legislation that authorized them could be said to represent the fundamental values of a democratic society. One may therefore ask, how can such admirable principles not produce more desirable results? The overall assessment of the CMHCs as a vehicle for providing for the mental health needs of society is receiving less than praise, as summarized by the following assessments:

Mental health programs are in deep trouble at both the state and national level... they are still lacking in the policies and programs that would make a community-based approach to mental health really feasible. (Caplan, 1980)

In the genus of social programs called human services, a species known as the federally funded community mental health center (CMHC) is in danger of extinction... (Sharfstein, 1977)

When one reviews the effectiveness of the CMHCs in dealing with the specific needs of ethnic minorities, the state of the art leaves much to be desired:

Despite the significant contribution made by the CMHCs there are still major gaps, particularly those services targeted to racial and ethnic minorities... Indeed, the present caregiving mental health services to racial and ethnic minorities by and large have been inappropriate and ineffective. (Owan, 1980)

Given these unfavorable, and overall pessimistic assessments of the CMHCs, and recognizing the forthcoming changing of the guard, both in the White House and on Capitol Hill, it is desirable to examine the status quo of the system in question. The assessment should not be conducted to seek a verdict about the future of the CMHC system since community-based treatment is required for some patients to comply with the legal mandate to provide care in the least restrictive environment. The nature of the assessment should be to determine if the CMHC system ever had a chance to fulfill the expectations of the Great Society, given the sociopolitical realities in which it was conceived and in which it has evolved. Consideration should also be given to the absence of planning to deal with the dynamics of change and innovation necessary to enable the CMHCs to

play their role in altering the status quo that existed prior to their inception.

The community mental health centers evolved in the midst of a sociopolitical reorientation that was precipitated as early as the Great Depression. Prior to the Great Depression, the frontier psychology which expressed itself in a "fierce pride towards self-reliance and independence from government" shaped the attitudes of lawmakers. The legislators stood fast and "locked in" to the Supreme Court's long-held interpretation of the Constitution "... as intending that the principle domestic powers and responsibilities of government should be exercised by states and their subdivisions... as reserved by the 10th Amendment of the Constitution" (Miles, 1974). This attitude was supported by Social Darwinism theories that permeated the country.

The Great Depression and its negative consequences upon the socioeconomic and psychological stability of society brought about a new consciousness in favor of egalitarianism. This concept could only have come about with an active federal mission to moderate and protect the national interest. The New Deal became the initiation of a new function for the federal government as an active participant in the area of human services which gave birth to a "broker state... a middle course between laissez-faire capitalism and socialism, broad social intervention without a planning capacity" (Graham, 1976).

It was under the broker state system that the first federal mental health policy was enacted, the National Mental Health Act of 1946 (P.L. 72-489). In keeping with the philosophy of the broker state system, the primary function of the Act was to serve as a resource to the states by: 1) providing information and data, 2) training personnel, and 3) facilitating the development of effective and efficient methods in mental health (Brusco, 1978). The recovery from the Great Depression through federal intervention began to yield some social tolerance that encouraged the liberalism and confidence to embark in the social planning, initiated by the federal government, to ameliorate and possibly eliminate some social problems.

The success of the community mental health concept to solve, alleviate and prevent mental illness assumed the following: 1) when the mental health problems were placed within the reach of the experts and their methods, a solution was guaranteed; 2) the necessary financial resources were readily available; 3) society was willing and able to accept the mentally dysfunctional once deinstitutionalization took place and to keep and care for clients for which institutionalization is not recommended; 4) the support services and systems for the continuity of care were (and would remain) readily available; 5) the treatment modalities available were universally applicable, or would be modified to apply to all without regard to sex, race, ethnicity, language, age and income status; and 6) the federal, state and local governments and their respective entities would respond and be responsible for their respective functions within the system (Kennedy, 1963).

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Genesis

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Unfortunately, few, if any of the aforementioned expectations ever existed or materialized. The inter-governmental planning that was the essential linkage of the Great Society programs that was to provide the support network to the CMHCs failed to materialize beyond the conceptualization stages (Miles, 1974). Those that crystalized in the form of grants-in-aid were so fragile that they were not able to withstand the politics of funding. The "seed monies" that represented the source of funding for the majority of the human service programs failed to germinate, much less produce fruit. Rufus E. Miles, Jr., who served as HEW's Director of Administration for over ten years, described an inherent shortcoming of federally funded programs:

grant programs present the most baffling management programs largely because they present a profound philosophical dilemma . . . which evolves in the concept of federalism which emphasizes the importance of state and local governments capable of initiative and adaption to the widely diverse conditions of an enormously varied nation. (Miles, 1974)

As successful as some human service programs have been, including some isolated CMHCs, discontent has continued and the mentality prior to the Great Depression is still making its presence known.

The sociopolitical system that created the changes that gave life to the CMHCs may also bring about the end to a noble idea that unfortunately was not given a chance. The current national trend against "liberals" and "liberal" ideas in Congress, as well as the negativism for federal intervention and the backlash in favor of states' rights, could bring down another program that was never truly implemented.

The intent of this analysis is not to discredit or undermine the noble ideas of the 1960s nor to attack the legitimacy of the new order. Instead, the intent is to record the concerns that most of us in the field have been expressing, and to begin a dialogue so that the changing of the guard in our federal government will not extinguish the hope for progress. To do so, we must re-issue the call for national planning, not only during this transition period, but also ongoing planning that can make mental health and other human service programs independent of "political capital," defined as the politicians' power to give and take in the negotiations that go on in the governing process (Miles, 1974).

Such national planning, for the management of change and innovation,

is indispensable if the United States is going to make sense out of its future . . . (Ferry, 1962)

REFERENCES

- Brusco, B.A. *Boards and councils of Texas Department of Mental Health and Mental Retardation*. San Antonio: Intercultural Development Research Association, 1979.
- Chu, F.D., & Trotter, S. *The madness establishment (Nader Report on the National Institute of Mental Health)*. New York: Grossman Publishers, 1974.
- Ferry, W.H. Caught on the horn of plenty. In J.A. Burkhardt, S. Krislow & R.L. Lee, (Eds.), *American government: The clash of issues* (3rd ed.) Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1968.
- Graham, O.L., Jr. *Towards a planned society: From Roosevelt to Nixon*. New York: Oxford University Press, 1976.
- Kennedy, J.F. Message from the President of the United States relative to mental illness and mental retardation. Washington, D.C. The White House, February 5, 1963.
- Klein, J. Background of patient rights in mental health. In National Institute of Mental Health, *Implementing standards to assure the rights of mental patients*. Washington, D.C.: U.S. Department of Health and Human Services, 1980.
- Mental health programs in trouble. *Institute for Social Research Newsletter*, Autumn 1980, Vol. 8, No. 4.
- Miles, R.E., Jr. *The Department of Health, Education & Welfare*. New York: Praeger Publishers, 1974.
- Musto, D.F. Whatever happened to "Community Mental Health"? *The Public Interest*, 1975, 39, 53-79.
- Owan, T.C. Neighborhood based mental health: An approach to overcome inequities in mental health service delivery to racial and ethnic minorities. In D. Biegel & A. Naparstek (Eds.), *Community support systems and mental health: Building linkages*. New York: Springer Publishing Co., 1980.
- Sharfstein, S. Will community mental health survive in the 1980's? Revised version of a paper presented at the 130th Annual Meeting of the American Psychiatric Association, Toronto, Ont., Canada, May 2-6, 1977.
- U.S. Commission on Civil Rights. *Twenty years after Brown*. Washington, D.C.: Author, 1975.

MHRP Seeking Applicants for Research Position

IDRA's Mental Health Research Project (MHRP) is currently seeking applicants for the position of researcher. The MHRP is an NIMH-funded study designed to assess the responsiveness of the Texas community mental health service delivery system to the needs of Mexican Americans. Requirements for the position include an M.A. or Ph.D. in the fields of psychology, social work or sociology. In addition, experience in the areas of field research and minority mental health would be beneficial. For further information, contact: David Ramirez, Project Director, Mental Health Research Project, IDRA, 5835 Callaghan Rd., Suite 350, San Antonio, Texas 78228 (512) 684-8180.

Special Committee Recommends Reform - Approaches Overlooks Bilingual/Multicultural

Sally J. Andrade, Ph.D.

The Special Committee on Delivery of Human Services in Texas, established by the Texas Senate in 1978 to study the human service delivery system in the state, released its report in November 1980. Entitled *The Potential in the Patchwork: A Future Pattern for Human Services in Texas*, the report is of importance to *Newsletter* readers because its recommendations are specifically targeted for legislative consideration in the 67th Regular Session of the Texas Legislature.

Major topics include:

1. the nature of the human service delivery patchwork as it currently exists in the state, including areas of omission, incongruities in statutes, and fragmentation of services;
2. changing populations and resources;
3. the increasing influence of the federal government;
4. problems in the system itself in terms of the governance of state agencies; and
5. a comprehensive policy planning and coordination mechanism to achieve the potential in the patchwork.

It is puzzling, however, that the report does not address issues arising from the racial and cultural diversity of Texas' population. This appears to be due to the Special Committee's examination of the service system which revealed that "the services themselves were not limited to any race, creed, or economic level" (Preface, p. v). This conclusion contradicts the findings of the IDRA Mental Health Research Project with respect to community mental health center services for Mexican Americans, as well as other studies regarding differential services for minorities (e.g., U.S. Civil Rights Commission, 1971-1974; Joint Committee on Prison Reform, 1974).

Ironically, the first three recommendations emerge out of concern for the plight of linguistically distinct refugees who only recently arrived in Texas, i.e., Southeast Asians, Cubans and Haitians. One addresses the need for foreign language interpreters in the courts, without noting the historical struggle of Mexican Americans to obtain their civil rights from the Texas judiciary system.

As another example, the report gives considerable attention to state population characteristics as important demographic indicators of future needs for human services, with an entire section focusing on juveniles and the elderly. Yet, the committee is apparently oblivious to ethnic diversity in terms of its impact in this respect. In another article in this newsletter, Ramirez and Sepúlveda Hassell point out the especially youthful composition of the Mexican American population in Texas in contrast to that of Anglos and Blacks (see Table 1). Yet, the Special

Committee does not address this crucial demographic characteristic in its discussion of the growing number of juveniles in Texas and the subsequent implications for the human service delivery system.

It is evident that the Special Committee on Delivery of Human Services in Texas has failed to acknowledge the importance of bilingual/multicultural approaches to human services. Therefore, all human service providers, other professionals and consumer advocates dedicated to the development and provision of bilingual/multicultural human services should be thoroughly familiar with the report and its recommendations in order to discuss these issues with key policymakers.

The Potential in the Patchwork: A Future Pattern for Human Services in Texas is available from the Texas Legislative Reference Library, P.O. Box 12488, Austin, Texas 78711 (512) 475-4226.

REFERENCES

- Joint Committee on Prison Reform. *Final Report of the Joint Committee on Prison Reform of the Texas Legislature*. Austin: State Legislature, 1979.
- United States Civil Rights Commission. *The Mexican American education study*. Reports 1-6. Washington, D.C.: U.S. Government Printing Office, 1971-1974.

Representation of Mexican Americans in MH Professions and Graduate Programs in Texas

by Criselda Segovia Price, M.A.

In its most basic form, a mental health service entails an exchange between a client and a service provider. The role of the mental health professional continues to be a decidedly key element in any intervention. If one is committed to the concept of bilingual/bicultural approaches to mental health services for Mexican American clients, it thus becomes imperative to assess the extent to which Mexican Americans are employed as service providers and the degree to which they have the opportunity to become trained and certified as mental health professionals.

As Tardy has pointed out:

it does not require an inordinate amount of clinical insight, or common sense for that matter, to realize that an English speaking therapist, for example, would find it difficult to conduct therapy with a Spanish speaking client. (Olmedo & Lopez, 1977, p. 80)

Studies have found that in the case of the Spanish speaking client, correct assessment of the client's problem, as well as the selection of an appropriate treat-

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FEDERAL NOTES

On October 7, 1980, President Carter signed into law the Mental Health Systems Act (PL 96-398). This piece of legislation will have a profound impact on the current system of mental health care in the United States. Thus, individuals involved in the delivery of mental health services must become acquainted with the Act and its implications as soon as possible. IDRA's Mental Health Research Project has followed the Act through its House and Senate versions, and is now studying the provisions and implications of the legislation in its final form for the Texas mental health system. In order to make the public more aware of the Act's contents, some areas of interest have been described below. *Newsletter* readers are encouraged to acquire a copy of the Act to familiarize themselves with the provisions in greater detail. The following information is quoted from a memorandum dated November 3, 1980, and written by Dr. Herbert Pardes, director of the National Institute of Mental Health. Again, only some sections of Dr. Pardes' review are detailed below:

The Mental Health Systems Act has its origins in the recommendations of the President's Commission on Mental Health (PCMH). This Commission, whose Honorary Chairperson was Rosalynn Carter, highlighted the need for a more flexible mental health service delivery system focusing attention on the needs of underserved and unserved population groups; especially the chronically mentally ill, children and youth, elderly, and minorities.

MAJOR THEMES

Adhering to the recommendations of the PCMH, the law passed by Congress and signed by the President—

- Revises Federal community mental health services by:
 - creating a more flexible initiation of comprehensive mental health services to all citizens in need
 - creating a national priority for care and support of the chronically mentally ill in the community
- Establishes a Federal-State-local mental health system
- Highlights the needs and provisions of services to the elderly, children and youth, and minorities.

Community Mental Health Centers (Section 201)

Grants may be made to any public or nonprofit private community mental health center to meet the costs of operating such a center. A community mental health center may receive these grants for operation for up to

eight years. The definition of the program and services of a community mental health center is included in the law (Section 101) and is similar in most respect to that defined by the CMHC Act.

Chronically Mentally Ill (Section 202)

Grants may be made to State mental health authorities, community mental health centers or other public or nonprofit private entities to provide mental health and related support services for chronically mentally ill individuals. . . . A grant for a project in a mental health service area (formerly a catchment area) served by a CMHC, may be made only to the CMHC or the State Mental Health Authority, unless the Secretary finds exceptional circumstances to indicate that the Chronically Mentally Ill would be better served by another public or private nonprofit entity.

Severely Mentally Disturbed Children and Adolescents (Section 203)

A project under this section must include at least one of the following services:

- identification and assessment of the needs of severely mentally disturbed children and adolescents and provision of mental health and related support services not provided by existing programs.
- assurance of the availability of personnel to provide and arrange for the provision of mental health and related support services.
- provision of auxiliary mental health services under the Education for All Handicapped Children Act of 1975.
- coordination between juvenile justice, educational authorities, and other authorities coming in contact with severely mentally disturbed children and adolescents for the provision of mental health and support services.

Priority Population Groups (Section 204 (b))

Grants may be made to a public or private nonprofit entity for a project to provide mental health services to one or more priority population groups in a mental health service area or to all residents of the mental health service area (formerly called a catchment area). . . .

A priority population group is defined as an identifiable population group which is unserved or underserved under a local Health System Plan or a State Health Plan (Section 102 (6)). . . .

The entity must have a plan to provide all of the above services and put this plan into effect by the end of its third year of operation.

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The grant for a project to provide mental health services to a priority population group is specifically designed for those mental health service areas that lack the resources to initiate a comprehensive mental health center, yet wants to meet the mental health needs of an unserved or underserved population group. Examples of such projects could include:

- mental health services for a minority group in an urban or rural area.
- mental health services for all the residents of a rural area which has insufficient resources to initiate a comprehensive community mental health center, but after the end of the four year project could start a community mental health center.

Mental Health Services in Health Care Agencies (Section 206)

Grants may be made to health care centers to provide mental health services to their patients. Two types of public or private nonprofit entities are eligible for grants.

- 1) An entity which provides mental health services which includes at least 24 hour emergency, outpatient, and consultation and education services and which has an affiliation agreement for the provision of health and mental health services.
- 2) A health care center which has in effect an affiliation agreement with a mental health services entity as defined above.

Innovative Projects (Section 207)

A grant may be made to a public or private nonprofit entity for

- training and retraining of employees adversely affected by the phasing down of State inpatient mental health facilities
- innovative use of personnel in the management of delivery of mental health services
- innovative project of national significance with respect to mental health services or personnel.

Prevention of Mental Illness and Promotion of Mental Health (Section 208)

Grants may be made to public or private nonprofit entities for prevention of mental illness and promotion of mental health as follows:

- maintenance and improvement of the mental health of individuals or groups susceptible to mental illness.
- prevention of the onset of mental illness or deterioration of the mental health in such individuals or groups susceptible to mental illness.
- education of the public regarding mental illness and the prevention of mental illness and the promotion of mental health.
- screening, consultation, referral and education in public school systems and in places of employment to detect and prevent mental health problems.

Associate Director for Minority Concerns (Title IV)

The position of Associate Director for Minority Concerns is established within the National Institute of Mental Health. The Associate Director is responsible for:

- developing and coordinating prevention, research, training, and service programs addressing the needs of minority population groups.
- studying the effects of discrimination on institutions and individuals.
- developing research, demonstration, and training programs designed to eliminate institutional discrimination.

The effective date for establishment of this position is October 7, 1980.

Mental Health Rights and Advocacy (Title V)

It is the sense of Congress that each State should review, and revise if necessary, its laws to ensure the protection of the legal rights of the mentally ill according to the recommendations of the President's Commission on Mental Health which are enumerated in Section 501.

Protection and Advocacy Programs (Section 502)

In fiscal year 1982 (or for the first year there is funding for this Section) a State may designate an entity of the State government or recommend a public or private nonprofit entity within the State as the applicant for a grant to protect and advocate the rights of the mentally ill. If an entity of the State applies for a grant that entity can not be a part of the State's mental health delivery program. Beginning in fiscal year 1983 (or the second year there is funding for this Section) grants may be made to any public or private nonprofit entity to protect and advocate for the mentally ill. In this latter case the Secretary will notify the Governor and allow a reasonable time for comment on the grant application.

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Representation

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ment technique, can be affected by language and cultural barriers. The expression of psychopathology was found to change as a function of language in bilingual psychiatric patients in general (Del Castillo, 1970; Marcos, Alpert, Urguys & Kesselman, 1973) and in Mexican Americans, in particular (Price & Cuellar, 1980). Other studies have indicated that monolingual English-speaking therapists who administer services to Spanish-speaking clients are likely to become frustrated and discourage clients from returning to treatment (Karno & Edgerton, 1969; Kline, 1969).

According to the National Board on Graduate Education (1976), the understanding of minority mental health needs and the availability of qualified professionals to respond to those needs are fundamental to the effectiveness of community mental health programs. Furthermore, the Health Revenue Sharing and Health Services Act of 1975 specifically includes a provision stating that a community mental health program serving a population with a substantial number of limited English speaking persons must have:

(i) developed a plan and made arrangements responsive to the needs of such population for providing services to the extent practicable in the language and cultural context most appropriate to such individuals, and (ii) identified an individual on staff whose responsibilities shall include providing guidance to such individuals and to appropriate staff members with respect to cultural sensitivities and bridging linguistic and cultural differences.

In the state of Texas, where Mexican Americans comprise approximately 20 percent of the population, it is thus imperative to determine the involvement of Mexican American mental health professionals in the community mental health system and also the pool of professionals that will be available to deliver these services in the future.

Utilizing Equal Employment Opportunity (EEO) data reported to the Texas Department of Mental Health and Mental Retardation (TDMHMR) in 1978 by 28 of the 29 community mental health centers (CMHCs), Fiedler (1979) found that Hispanics were employed in professional positions at the centers at a lower proportion than their representation in the population in Texas. Hispanic professionals comprised only 12 percent of the professional workforce in the CMHCs, whereas 74 percent of the workforce was comprised of Anglos. Additionally, Sepúlveda Hassell (1980) pointed out that 132 (70 percent) out of the 189 Hispanic professionals were employed at five CMHCs located in the state's metropolitan areas, while the remaining 57 (30 percent) were distributed among the other 23 CMHCs. Data further indicate that six of the centers reporting an ethnic breakdown of employed professionals had no Hispanic professionals on their staffs. As Sepúlveda Hassell (1980) reported, the majority of the CMHCs in Texas are seriously underrepresented with regard to Hispanic professionals

and have even fewer Mexican American mental health professionals on their staffs.

Since the number and proportion of Mexican Americans in the mental health professions is dependent on their enrollment and completion of mental health training programs in colleges and universities, the IDRA Mental Health Research Project attempted to identify the potential pool of Mexican American mental health professionals in Texas by investigating the ethnic representation of graduate students in the state's programs of psychiatry, psychology, social work and psychiatric nursing.

Of the 42 programs at Texas institutions of higher education that were contacted for the study, 32 (76 percent) responded to the mail survey questionnaires and/or participated in the site interviews. Programs responding included nine of the 11 programs in psychiatry, 14 of the 22 programs in clinical and/or counseling psychology, four programs in social work, and four of the five programs in psychiatric nursing.

A preliminary analysis indicates that the underrepresentation of Mexican Americans in the four respective fields prevails, in that Mexican Americans are not represented in these fields in equal proportions to their percentage of representation in the state's population (20 percent).

Psychiatry. The underrepresentation of Mexican Americans in psychiatric programs during the last five years has ranged from 3.5 percent in 1975-1976 to 2.0 percent in 1977-1978. In 1979-80, Mexican Americans comprised only 3.5 percent (five students) of the total enrollment in these programs.

Psychology. The Mexican American representation in Ph.D. clinical and counseling psychology programs has remained about the same from 1975 to 1979-80. This representation has constituted about 7.0 percent, or 14 students, of the total enrollment for each academic year. Since these programs are four-year programs, the number of Mexican American students in each individual class varies from three to four. Mexican American students represent 8.0 percent (29 students) of the total enrollment in master's level clinical and counseling psychology programs. It should be pointed out, however, that 23 of these students are enrolled in one program, indicating a serious underrepresentation in the other eight master's level programs. The program reporting the 23 students in the present enrollment, however, did not report data for 1975-1978. Indeed, the representation of Mexican Americans in these programs from 1975 to 1978 ranged from 1.0 percent (two students) to 3.0 percent (five students). Thus, the underrepresentation of Mexican Americans is evident in all the programs.

Social Work. While Mexican American enrollment in social work programs began to reach a level equivalent to the proportion of Mexican Americans in the population in Texas during the academic years of 1975-76 and 1976-77, their representation in these programs in 1979-80

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declined. During the previous years, the percentage of Mexican American representation remained at 20 percent. This percentage dropped to 17 percent in the 1977-78 school year, however, and in 1979-80, Mexican American enrollment declined to 12 percent (48 students) of the total number of social work graduate students.

Psychiatric Nursing. Mexican Americans only comprised 3.0 percent (five students) of the 1979-1980 total enrollment in psychiatric nursing programs. The data indicate that there was a decline in Mexican American enrollment. In 1977-78, Mexican Americans represented 8.0 percent, or eight students, of the total program enrollment.

Barriers to Training

The National Board on Graduate Education (1976) cites four possible barriers that potentially affect minority participation in graduate education. These institutional barriers are financial, educational, psychosocial and cultural. Methods to eliminate these barriers, however, have not been fully implemented. In addition, legal and voluntary efforts, in the form of Title VI and affirmative action plans, that have been initiated to promote Hispanic participation in higher education, have been met with institutional resistance and numerous delays in implementation. Thus, they have often had limited success in attaining their goals.

In summary, while the need for mental health professionals that can provide appropriate and acceptable mental health services from a linguistic, as well as a cultural, perspective to Spanish-speaking clients continues, these professionals remain unavailable in the mental health delivery system and the problems associated with the issue remain unsolved. Since it is the institutions of higher education, through their training programs that develop the human resources and certified personnel, that can alleviate this need, a large amount of the responsibility for meeting the demand for mental health services to Mexican Americans lies within the realm of these colleges and universities. The responsibility of fostering an awareness of this need, however, also lies within the realm of the mental health delivery systems. In this case, if the mental health delivery system is to provide adequate services to Mexican Americans, it must depend on the state colleges and universities to train bilingual/bicultural professionals, as well as to sensitize monolingual Anglo and Black professionals to the needs of the Mexican American population. Conversely, if the institutions of higher education are to respond to the needs of society, they must keep the channels of communication open with the systems that can identify these needs. Furthermore, it is particularly important that both systems interact with indigenous leaders from the Mexican American community.

REFERENCES

Del Castillo, J.C. The influence of language upon symptomatology in foreign born patients. *American Journal of Psychiatry*, 1970, 11, 467-469.

Fiedler, F.P. *Utilization, staffing and community profiles*:

Vol. 2 No. 4

Community mental health mental retardation centers in Texas. San Antonio: Intercultural Development Research Association, 1979.

Karno, M., & Edgerton, R. B. Perception of mental illness in Mexican American community. *Archives of General Psychiatry*, 1969, 20, 233-238.

Kline, L.Y. Some factors in psychiatric treatment of Spanish Americans. *American Journal of Psychiatry*, 1969, 125, 1674, 1681.

Marcos, L.R., Alpert, M., Urcuyo, L., & Kesselman, M. The effect of language on the evaluation of psychopathology in Spanish American schizophrenic patients. *American Journal of Psychiatry*, 1973, 130, 549-553.

National Board on Graduate Education. *Minority group participation in graduate education*. Washington, D.C.: 1976.

Olmedo, E.L., & Lopez, S. Summary analysis and recommendations. In E.L. Olmedo & S. Lopez (Eds.), *Hispanic Mental Health Professionals*. Los Angeles: Spanish Speaking Mental Health Research Center, Monograph No. 5, 1977.

Price, C., & Cuellar, I. The effects of language and related variables on the expression of psychopathology in Mexican American psychiatric patients. Article submitted for publication, 1980.

Sepúlveda Hassel, S. *An assessment of the mental health treatment process: Eliminating service barriers for Mexican Americans*. San Antonio: Intercultural Development Research Association, 1980.

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Prior to the implementation of collaborative services between the mental health system and other social systems, comprehensive integrated planning must occur among the various service systems. The likelihood of that occurring is affected by staff predisposition, administrative support, agency policies and guidelines, and the philosophical orientation of the service system. As the mental health service system is generally operated, the client in need of services must recognize the problem, be aware of the availability of mental health services in the community and have a means to access the service. This is particularly difficult for children, who are dependent upon adults to take the initiative throughout the process, and particularly for Mexican American children whose parents are all too often also ignored by the mental health service system.

A collaborative inter-agency effort to address the needs of children in their routine social environments would appear to be one means to reduce the underutilization of community mental health services by Mexican American children and other children in need of services. Perhaps this more comprehensive service effort involving the combined participation of many service providers not previously considered a part of the mental health field will enable the avowed commitment to the mental health care of children to be more fully realized for Mexican American children and all children currently being underserved by the community mental health service system.

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REFERENCES

- Allen, G.J., Clinsky, J.M., Larcen, S.W., Lochman, J.E., & Selinger, H.V. *Community psychology and the schools: A behavior oriented multilevel preventive approach*. Hillsdale, New Jersey: Lawrence Erlbaum Associates, Publishers, 1976.
- Berkowitz, H. A preliminary assessment of the extent of interaction between child psychiatric clinics and public schools. *Psychology in the Schools*, 1968, 5, 291-295.
- Calhoun, J.A., Grotberg, E.H., & Rackley, W.R. *The status of children, youth and families, 1979*. Washington, D.C.: U.S. Department of Health and Human Services, 1980.
- Dohrenwend, B. P., Dohrenwend, B.S., Gould, M.S., Link, B., Neugebauer, R., & Wunsch-Hitzig, R. *Mental illness in the United States*. New York: Praeger Publishers, 1980.
- Florez, J. Issues and problems affecting Hispanic youth: An analysis and a blueprint for action. In M. Montiel (Ed.), *Hispanic families; critical issues for policy and programs in human services*. Washington, D.C.: National Coalition of Hispanic Mental Health and Human Service Organizations, 1978.
- Gavillan-Torres, E. Answering the needs of Hispanic handicapped children: Facts and issues. *Cutting edge*, 1980, 1, New York: Hispanic Educational Research Today, Aspira Center for Educational Equity.
- Glasscote, R.M., Fishman, M.E., & Sonis, M. *Children and mental health centers: Programs, problems, prospects*. Washington, D.C.: American Psychiatric Association, 1972.
- Graham, P., & Rutter, M. Psychiatric disorder in the young adolescent: A follow-up study. *Proceedings of the Royal Society of Medicine*, 1973, 66, 1226-1229.
- Group for the Advancement of Psychiatry. *Crisis in child mental health: A critical assessment*. New York: Group for the Advancement of Psychiatry, Volume VIII, Report No. 82, 1972.
- Joint Commission on Mental Health of Children. *Crisis in child mental health: Challenge for the 1970's*. New York: Harper and Row, 1969.
- Joint Commission on Mental Illness and Health. *Action for mental health*. New York: Science Editions, 1961.
- Kellam, S., Enslinger, M., & Turner, R.J. Family structure and the mental health of children: Concurrent and longitudinal community wide studies. *Archives of General Psychiatry*, 1977, 1012-22.
- Langner, T.S., Gersten, J.C., & Eisenberg, J.G. Approaches to measurement and definition in the epidemiology of behavior disorders: Ethnic background and child behavior. *International Journal of Health Services*, 1974, 4, (3), 483-501.
- National Commission on the International Year of the Child. *Report to the President on the International Year of the Child*. Washington, D.C.: U.S. Government Printing Office, 1980.
- Ramirez, B.C. The making of social policy in the U.S. - Some issues important to Hispanics. *Mental Health Research Project Newsletter*, Intercultural Development Research Association, San Antonio. Fall, 1979.
- Ramirez, D.G. *Analysis of the patterns of use of community mental health services by Mexican Americans in Texas*. San Antonio: Intercultural Development Research Association, in press.
- Report of the Sub-Task Panel on Infants, Children and Adolescents. *Task panel reports submitted to The President's Commission on Mental Health, Vol. III*. Washington, D.C.: U.S. Government Printing Office, 1978.
- Report of the Special Populations Sub-Task Panel on Mental Health of Hispanic Americans. *Task panel reports submitted to the President's Commission on Mental Health, Vol. III*. Washington, D.C.: U.S. Government Printing Office, 1978.
- Rosenbaum, S. The Medicaid early and periodic screening diagnosis and treatment program: HEW's new regulations. *Clearinghouse Review*, 1980, February, 742-748.
- Rutter, M., Cox, A., Tupling, C., Berger, M., & Yule, W. Attainment and adjustment in two geographical areas. The prevalence of psychiatric disorder. *British Journal of Psychiatry*, 1975, 126, 493-509.
- The Vice President's Task Force on Youth Employment. *A summary report*. Washington, D.C.: The White House, 1980.



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THE TCA TEXAS STATE PLAN: THE PERSPECTIVE OF 'SPECIAL POPULATIONS'

Sally J. Andrade, Ph.D.

The philosophy from which the Texas Commission on Alcoholism (TCA) developed the 1980-81 *Texas State Plan* was one of considering progress and priorities in terms of "services designed to meet the needs of all Texas residents." Those needs and their appropriate services include:

1. *Primary Prevention*: Services for persons who have not developed a drinking problem, designed to prevent such problems from developing.
2. *Secondary Prevention*: Services designed to intervene in the early states of abuse or addiction.
3. *Treatment and Rehabilitation*: Services for the problem drinker and his/her family, which are designed to treat the individual and promote responsible, healthy living (*Texas State Plan*, 1980, p. I-1).

In the *Plan's* section on needs assessment and data analysis, the commission notes a Texas Department of Health 1980 population projection for the state of Texas as having 13,900,000 inhabitants. Whites or Anglos comprise 67 percent of the population, Hispanics 20.7 percent, Blacks 12 percent, and other ethnic groups less than 1.0 percent, with minorities or ethnics of color making up one third of the state's total inhabitants. TCA estimates that in Texas there are about 665,000 problem drinkers over age 20 and another 124,000 adolescent problem drinkers aged 13-20. The commission cites the National Institute on Alcoholism and Alcohol Abuse's calculation that approximately four persons are adversely affected by each problem drinker, thus suggesting that more than three million family members and friends in Texas suffer from negative effects of alcohol use and abuse.

In relation to the impact of alcohol on Mexican Americans in Texas, the *TCA Plan* presents some limited data which may indicate serious problems. While there are no alcohol arrest data available for Hispanics as a group (they are included with Whites), the *Plan* documents that 34 percent of the 3,478 juvenile referrals to county juvenile probation departments for possession of alcohol in 1978 were Hispanic adolescents. Further-

more, 44 percent of the 1,412 juveniles actually detained in a secure detention facility that year were Hispanic, an extraordinarily high rate and one which indicates an overrepresentation of Hispanic adolescents in the criminal justice system. These figures are particularly important in light of the fact that 37 percent of all persons arrested for liquor law violations in Texas are juveniles. In terms of health impact, about 16 percent of the alcohol-specific deaths in Texas during 1978 were Hispanics, primarily due to cirrhosis of the liver.

Treatment data from the Texas Department of Mental Health and Mental Retardation presented in the *TCA Plan* indicate that 18,600 individuals received treatment services in 1978, from either an inpatient unit at a state hospital, or from an outpatient program of a state hospital outreach center or a community mental health center. Overall, 18 percent of these clients were Hispanic. The *Plan* notes, however, that Hispanics were significantly underrepresented among clients served at state hospital inpatient and outreach treatment centers, with the majority of them being seen at community mental health centers.

Client data from TCA-funded treatment and rehabilitation programs indicate much lower service levels for Hispanic patients, with only 11.4 percent of Mexican Hispanic individuals receiving inpatient, rehabilitation and outpatient services, and only 10.3 percent of Mexican Hispanic individuals receiving information, referral and outreach services from such programs. Other Hispanics received 1.0 percent or less from both categories of service.

Accomplishments of 1979-80 Program Year

The Progress Report on the 1979 Action Year notes the eight goals of the Texas Commission on Alcoholism *State Plan*, among which is included in the following:

4. *Special Populations*: To assure that alcoholism services, knowledge, and materials are made available to the following special populations: women, youth, Blacks, Mexican Americans, elderly, poverty, and handicapped (*Texas State Plan*, 1980, p. III-1).

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TCA

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Yet, a review of the section which relates progress achieved toward addressing those goals and the 59 specified objectives does not provide much information about provision of services, knowledge and materials to Mexican Americans (or to other "special populations," for that matter).

For example, only two of the 59 objectives focus on such groups. One reads, "Objective: To inform special programs about state and national issues and projects that could affect such programs" (*Texas State Plan*, 1980, p. III-10).

The activities documented under this objective include:

1. the publication of four TCA Magazine articles, focusing respectively on a women's residential care unit, family violence and alcoholism, the Mexican American family and children of alcoholics;
2. the purchase of five films, one about Mexican Americans, one about the elderly, and three for youth; four new literature pieces (elderly, women, children, teenagers) and one Spanish translation;
3. a workshop on special populations at the TCA Annual Institute of Alcohol Studies;
4. an article about women alcoholics printed in the TDMHMR newsletter; and
5. the funding of two grants by TCA, one to utilize public and print media to educate Black, Hispanic and low-income residents in State Planning Region 20 (Southeast Texas) and one to provide educational presentations and workshops to Black, Hispanic, American Indian and female residents of State Planning Region 14 (Nacogdoches/East Texas area).

The second objective reads, "Objective: To encourage the funding of existing and new programs that primarily serve special populations" (*Texas State Plan*, 1980, p. III-19). The objective discusses the provision of information, films, literature and technical assistance to TCA's Area and Regional Offices, and to interested individuals and agencies; program development assistance to facilitate implementation of regional priorities; site visits to all 24 TCA-funded programs serving women, youth, ethnic minorities, and senior adults; and the development of plans for a joint effort with the Texas Department of Human Relations — a domestic violence program to help abused or neglected children. It also notes that seven special population programs received new or continuation funding from TCA in 1979.

One other objective records the continued active involvement of the Texas Commission on Alcoholism as a

liaison with the Texas Task Force on Women, Alcohol and Other Drugs, the Alcohol and Drug Concerns Among Older Persons, the Crime Prevention/Drug Education Committee, and the Well Child Conference of Directors (*Texas State Plan*, 1980, p. III-19).

There are references to other activities or materials developed for special population groups in some of the other objectives; the primary strategy for Mexican Americans appearing to be that of translating existing materials (slide shows, pamphlets, educational curricula). It should be noted that each of the 24 State Planning Regions developed separate sets of goals and objectives, and several address the needs of Mexican Americans or Spanish-speaking individuals. Some areas that have high concentrations of Mexican Americans, however, do not have any objectives that target that group.

TCA Plans for the Current Program Year

The Action Plan section outlining goals and objectives for 1980-81 specifies two objectives and seven additional implementation strategies which specifically target services for special populations.

*GOAL: PRIMARY PREVENTION

OBJECTIVE: To provide services to high-risk populations and other special groups in order to reduce the incidence and effects of alcohol addiction and abuse.

IMPLEMENTATION STRATEGIES

Develop one model program for children of alcoholics.

Provide technical assistance to the Austin Family House in the development of their program for children of alcoholic females.

Coordinate a statewide Fetal Alcohol Syndrome Awareness campaign.

Work with the Department of Human Resources to obtain services for children who are victims of family

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violence, abuse or neglect as a result of alcohol addiction or abuse. (*Texas State Plan*, 1980, p. IV-10)

***GOAL: TREATMENT AND REHABILITATION**

OBJECTIVE: To identify funding sources and assist, as feasible, in the development and coordination of specialized treatment and rehabilitation programs serving special populations including women, youth, ethnic minorities, senior adults, the handicapped and victims of domestic violence.

IMPLEMENTATION STRATEGIES

Provide technical assistance to individuals and agencies seeking to develop alcohol treatment and rehabilitation programs for special groups.

Review applications to TCA requesting federal formula funds for special populations.

Participate in appropriate committees, task forces, and advisory groups which focus on needs of special populations.

Develop a model treatment program for juveniles; seek funding, site and sponsor to implement the program. (*Texas State Plan*, 1980, p. IV-25)

***GOAL: PRIMARY PREVENTION**

OBJECTIVE: To increase the number of primary prevention programs in the State of Texas from 5 to 10.

IMPLEMENTATION STRATEGIES

(#2) Provide technical assistance to those interested in developing primary prevention programs, including programs for special population groups.

(#5) Revise application kit guidelines and standards for primary prevention proposals to include those for special population groups. (*Texas State Plan*, 1980, p. IV-7)

***GOAL: PRIMARY PREVENTION**

OBJECTIVE: To provide alcohol information and education for over 50,000 students in Texas public schools.

IMPLEMENTATION STRATEGIES

(#4) Provide technical assistance to the Texas Parent Teachers Association in development of statewide primary prevention programs for their members, including special materials for Hispanic parents. (*Texas State Plan*, 1980, p. IV-9)

***GOAL: SECONDARY PREVENTION**

OBJECTIVE: To assist in the development of councils on alcoholism and other intervention programs for communities and professional organizations.

IMPLEMENTATION STRATEGIES

(#2) Review applications for funding to develop councils on alcoholism and community intervention programs including those programs focusing on

special population groups. (*Texas State Plan*, 1980, p. IV-19)

***GOAL: SECONDARY PREVENTION**

OBJECTIVE: To provide alcohol addiction and abuse educational materials at cost or free to the Texas public.

IMPLEMENTATION STRATEGIES

(#1) Conduct a publicity campaign on films and literature for the Spanish speaking population available through TCA's Film and Literature Library. (*Texas State Plan*, 1980, p. IV-21)

***GOAL: TREATMENT AND REHABILITATION**

OBJECTIVE: To provide counseling skills training to 3,000 alcoholism direct service providers.

IMPLEMENTATION STRATEGIES

(#8) Assist RAAs (Regional Alcoholism Authorities) and state and local agencies and organizations in planning and conducting workshops focusing on the unique treatment and rehabilitation needs of women, ethnic minorities, youth, senior adults, rural residents, the handicapped, and other special populations. (*Texas State Plan*, 1980, p. IV-29)

***GOAL: TREATMENT AND REHABILITATION**

OBJECTIVE: To provide counseling skills training to 3,000 alcoholism direct service providers.

***GOAL: ADMINISTRATION AND PROGRAM SUPPORT**

OBJECTIVE: To refine and expand the information systems currently maintained by TCA for planning, development and informational purposes.

IMPLEMENTATION STRATEGIES

(#2) Examine feasibility of revising TCA's Management Information System to provide more meaningful information by types of services, age and ethnicity. (*Texas State Plan*, 1980, p. IV-39)

The 24 regional plans allude objectives, some of which refer to special populations. But, as in the previous year, several regions with high concentrations of Mexican Americans do not focus their objectives on that population.

Summary

An assessment of the Texas Commission on Alcoholism's accomplishments in meeting its goal of services for special populations in 1979-80 must conclude that there was very limited success. Nevertheless, the *Texas State*
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MEXICAN AMERICAN MENTAL HEALTH: ISSUES TO ACTION



MHRP CONFERENCE

MEXICAN AMERICAN MENTAL HEALTH: ISSUES TO ACTION

DATE: MAY 1-2, 1981

LOCATION: Joe C. Thompson Conference
Center — Austin, Texas

CONFERENCE FOCUS:

The IDRA Mental Health Research Project, funded by the National Institute of Mental Health, has worked toward the goal of improving Mexican American mental health services delivery. The project's accomplishments have included an analysis of the state mental health services delivery system and an assessment of the community mental health center concept in terms of their effectiveness in providing services to Mexican Americans. The focus of this conference is to disseminate research findings and solicit constructive suggestions for improving agencies' provision of mental health services to Mexican Americans. Participants are invited from the spectrum of mental health service workers, and the governmental and public sectors.

For more information call or write Mental Health Research Project, IDRA, 5835 Callaghan Rd., Suite 350, San Antonio, Texas 78228 (512) 684-8180.

AN OVERVIEW OF PATIENTS' RIGHTS IN MENTAL HEALTH

by Alfonso Lopez-Vasquez

IDRA's Mental Health Research Project has received a planning grant to initiate research in the area of patients' rights and advocacy issues, and their implications for ethnic minorities, specifically Mexican Americans. The purpose of this article is to provide a preliminary overview of the broad parameters of patients' rights and related issues as defined in current National Institute of Mental Health (NIMH) literature.

Advocacy in the United States on behalf of the mentally ill and mentally retarded has a long history. The asylums that were established in the 1800s came about as a result of the advocacy movement seeking more humane care and moral treatment for the mentally ill (NIMH, 1980).

It could be said that advocacy continued to be advanced from within the institutions by the medical

profession, specifically by personnel in psychiatry who continued to develop the knowledge base and technology needed to ameliorate and remedy some of the symptoms of mental illness and mental retardation. However, the absence of adequate technology and sufficient operating budgets precipitated overcrowded and prison-like environments in many publicly-operated institutions. These conditions, "... made the mental institutions frightening and depressing places in which the rights of the patients were all but forgotten" (NIMH, 1980 p. 1).

The first to abhor the conditions that existed in the mental institutions were the patients, some of whom had been committed without adequate diagnosis and without regard to due process. Once out of institutions, ex-patients were able to voice their criticisms about a system that not only failed to provide patients with adequate care and treatment but also victimized them through abuse and neglect.

According to Perlin and Martin (1980), the mental health system's operations have systematically deprived patients of their constitutional rights. This characterization and the findings regarding cases of neglect, abuse and

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disregard for the rights of mental patients have served as the impetus for the patients' rights movement as we know it today.

Advocates for the mentally ill and mentally retarded historically have sought to respond to the broad range of needs of these persons. However, there was neither specific strategy nor focus upon which these advocates could concentrate until the late 1960s. The civil rights movement and the activism of the same decade encouraged patients' rights advocates to seek remedy to this situation through civil liberties cases in the courts.

The most important achievement of the advocacy movement on behalf of the mentally ill and mentally retarded during the 1970s was the establishment of "... standards to patients' rights as an integral part of the overall standards program ..." (NIMH, 1980, p. 11) of the mental health delivery system.

History of Litigation

In order to understand the dynamics of the patients' rights movement, it is important to review its litigative history. Some of the most significant cases affecting the mental health delivery system have been categorized (Kopelow, 1976) into the following mental health areas: institutional psychiatry, civil rights of patients, the patient-therapist-public relationship, and the treatment of patients within the criminal justice system.

Cases related to institutional psychiatry concern the right to treatment for mentally disordered persons who are involuntarily committed through civil proceedings (*Wyatt v. Stickley*), as well as those who are voluntarily committed (*Donaldson v. O'Connor*).

In *Wyatt v. Stickley* (1972), the district court issued an order "... setting standards and a detailed program for implementation which included: a provision against institutional peonage; a number of protections to a human psychological environment; minimum nutritional requirements; a provision for individualized evaluation of residents, habilitation plans, and programs; minimum staff to patient ratios; and a requirement that every mentally impaired person has a right to the least restrictive setting necessary for treatment" (Kopelow, et al., 1976, p. 5).

The *Donaldson v. O'Connor* (1975) case endorsed the right to treatment and further advanced the requirement that treatment be conducted in the least restrictive environment. The U.S. Supreme Court "... ruled that there was a constitutional right to liberty and that a person who was not dangerous could not be confined in a mental hospital against his will ..." (Perlin & Martin, 1980, p. 11).

Commitment procedures were addressed in detail in *Lessard v. Schmidt* (1972). "The federal district court in Wisconsin ruled that procedural due process applies when a person would lose his/her liberty through commitment. It also applied the concept of the least restrictive

alternative ... holding that a person could not be committed until a judicial examination had been made of less drastic alternative means for dealing with that person" (Perlin & Martin, 1980, p. 11).

Cases included in the second major area have centered around the civil rights of the mentally disordered to assure them the same rights as all other citizens in the areas of wages, education and living arrangements. *Sonder v. Brennan* established the right of mentally ill patients to receive fair compensation for their work (Kopelow, 1976). The right to education historically had been denied to the physically and mentally handicapped. The *Mills v. Board of Education of the District of Columbia* (1972) case, among others, established the right of the handicapped to an appropriate education (Kopelow, 1976).

The patient-therapist-public relationship is becoming increasingly complex as the patients' rights movement continues to redefine the traditional patient-therapist relationship. The dyadic relationship that had prevailed prior to the patients' rights movement had as its boundaries the ethics of the profession which in essence maintained a "doctor knows best" philosophy. The rights of the patient during the treatment process were determined by the therapist, and the confidentiality of information was not to be challenged. The patient-therapist-public relationship has precipitated, among others, the right of informed consent to accept or refuse treatment, third-party payor involvement and the accountability being mandated by the advocates for patients' rights (Kopelow, 1976).

By far one of the most complex and socially sensitive issues concerning the spectrum of patients' rights is the conflict that has arisen between the criminal justice system and the mental health profession in addressing the criminally insane. In the past, the medical and legal professions maintained compatible attitudes towards the criminally insane; such persons were considered a threat and burden to society, requiring exclusion from society by commitment to hospitals for the criminally insane. The last decade, however, has proven to be one of great conflict resulting from changing perceptions on the subject of treatment of the criminally insane.

The divergence in views between law and psychiatry ... is not over the question of responsibility, for both law and psychiatry would assume individual personal responsibility. The divergence is over the question of what should be done with those whose unlawful acts indicate that their sense of personal and social responsibility is insufficient to hold their behavior within the law ... The lawyers declare that when laws have been violated the

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culprits must be convicted and punished. The psychiatrists say that punishment has no salutary effect on many such persons . . . that many would be more likely to become rehabilitated through treatment . . . than through punishment. (Ford, 1970, p. 264)

The complexity of this issue is obvious. A major conflict has arisen, too, between the judicial requirement to monitor patient treatment to ensure patient rights and the ethical requirement of doctor-patient confidentiality.

Court-ordered change, in an attempt to ensure patients' legal rights, complicates the already difficult task of giving adequate care and treatment to those who most need it. . . (Kopolow, 1976, p. 16)

Rights Defined

What follows is a partial but representative listing developed by NIMH (1980) of rights to which patients or clients are entitled, as defined by recognized human, legal, constitutional and civil rights laws and standards, as well as a functional definition for each as it applies to the mental health delivery system.

Patient Rights—the privileges and entitlements of patients in a mental health system.

There are many ways in which mental patients may be injured or compromised if an agency is not aware of the possibilities, sensitive to them, and alert to assure that the patients and their rights are protected. . . . Some of the rights are more sensitive, and thus more critical in terms of legal accountability, than others. Some of the major categories are:

Civil Rights—the basic rights of any citizen in our society, whether a mental patient or not, such as:

- a) The right to vote.
- b) The right to buy and sell property.
- c) The right to marry.

Until recent years, most mental patients were declared incompetent and deprived of their civil rights as part of the basic commitment process. . . . Procedures and standards are needed to assure that patients are made aware of their civil rights and aware that, despite their status as patients, they have the ready means to exercise these rights. Achieving one's civil rights is especially difficult for patients in institutions such as mental hospitals and schools for the mentally retarded.

2. **Legal Rights**—the special legal rights of patients in mental health institutions and programs.

These include the right:

- a) To contact and be represented by an attorney.
- b) To seek a writ of *habeas corpus*.
- c) To file complaints with responsible authorities.

These special legal rights are often spelled out in the state's mental health statutes. Although mental health workers have an increased consciousness about patient rights, the patients themselves are often ignorant of these rights, in large part because no one has made the effort to give them the necessary knowledge.

3. **Human Rights**—basic rights of persons as human beings.

These are the common rights of people throughout our democratic society. Human rights are not unique to mental patients, nor are they the result of specific laws or legal procedures. . . . This area requires special sensitivity by all levels of mental health programs—both institutional and community level. Among the human rights are:

- a. The right to a *safe environment*—this includes conditions such as:
 - Clean facilities and equipment.
 - Buildings that are safe and in good repair.
 - A balanced diet of food that is clean, safe, and wholesome.
 - Physical care and medical services for persons in total institutions.
 - Assurance of protection from threats or assault from staff or other patients.
- b. The right to an *esthetic and humane environment*, including, for example:
 - Warm and cheerful furnishings.
 - Design and grouping of facilities and furnishings to allow for alternative social living activities (small groups, quiet areas, game areas, television areas, etc., which are separated from each other).
 - Meals attractively and pleasantly served with home-like china and utensils.
 - The right to have visitors.
 - The right to have and use smoking materials.
 - The right to flexible and humane schedules and procedures for arising, bathing, eating, etc.
- c. The right to *privacy and personal freedom*, including:
 - Freedom to come and go upon reporting one's planned activities.
 - Freedom from unnecessary seclusion or restraint.

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- Freedom to wear individualized and personal clothing.
 - A private place for keeping one's personal effects.
 - The right to have money and spend it as one wishes.
 - The right to receive and send mail.
 - The right to make telephone calls.
 - The right to confidentiality of records and information.
 - The right to review one's own clinical records.
4. Right to treatment—the entitlement of a person in the mental health system to an early and adequate diagnosis and course of treatment.

This is a relatively recently defined right of patients as courts have insisted that, without definitive treatment, persons cannot be held for prolonged periods of observation or detention on suspicion or even demonstration of mental disorder. The right to treatment includes:

- a. The right to an early diagnostic evaluation, often with specified steps leading to a diagnosis, including:
 - The right to physical evaluation as well as mental diagnosis.
 - The right to (treatment) in the least restrictive environment.
 - The right to expeditious release or transfer upon a decision to take such action.
- b. The development and maintenance of an individualized treatment plan, including:
 - The right of informed consent by the individual with assurance that the procedures have been explained in jargon-free, comprehensible terms.
 - The spelling out of specific elements, goals, and steps in the treatment plan.
 - The right to a schedule for review and update of the plan.
 - The right to treatment in the least restrictive alternative.
 - Access to the treatment plan by the patient and all members of the clinical team.
 - Special attention to medications (e.g., concern for a patient's idiosyncracies and allergies).
 - The right to special education when needed.
 - The right to recreation.
 - The right to know what disciplinary procedures will be meted out for antisocial behaviors.
 - The right to professional review of treatment.
- c. Special attention and safeguards regarding certain treatment procedures, especially those that are intrusive:

- Electroconvulsive therapy.
- Behavior modification therapy (especially aversive procedures).
- Intramuscular injections of psychotropic medications.
- Psychosurgery.
- Reality therapy.

5. *Other Unique Rights Pertaining to Mental Patients*—rights which apply because of the unique risks to patients in mental health programs. These rights include:

- a. The right to adequate payment for labor performed.
- b. The right to refuse treatment.
- c. The right to be informed and review experimental or research procedures and the right to withhold consent thereto.

Other patient rights are still emerging, just as various rights are in the larger society. These include the right to sexual expression, and the rights of the physically handicapped (blind, deaf and crippled) mental patient.

In addition to the spectrum of rights as defined above, there are also numerous legislative and policy mandates as well as administrative procedures evolving from both federal and state regulations or standards. Augmenting the complexity of the patients' rights issue is the fact that deinstitutionalization, the provision of treatment in the least restrictive environment, and continuity of care require the involvement of more than one agency. Often, the agencies providing or expected to provide services to the mentally ill and mentally retarded are not within the domain and auspices of the mental health system.

The advocacy movement for patients' rights has found the judicial and legislative systems to be the most expedient sources of assistance to bring about institutional change within the mental health system on behalf of the mentally ill and mentally retarded. As effective as these efforts have been in defining and ensuring standards of care, they have failed to materialize in long lasting, viable improvements in the provision of rights and effective care of the patients (Bailey, 1980). The gains and victories in judicial recognition to date "... may turn out to be hollow ... unless society as a whole, along with the mental health and legal communities, is willing to provide for the kind of treatment and support that will enable mentally ill persons whenever possible, either on their own or with the help of family or friends, to live in the community" (Brown, 1975, p. 7).

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*The Spanish speaking aged compose a particularly vulnerable class of needy persons within an already disadvantaged population of elderly Americans. Due to linguistic and cultural barriers, physical isolation and the disadvantages endemic to minority group status, the Spanish **viejito** finds himself in even more deplorable circumstances than the majority of the American elderly population. (White House Conference on Aging, 1971)*

MEXICAN AMERICAN ELDERLY: ARE THEIR SERVICE NEEDS UNDERSTOOD AND ADDRESSED?

by Sharon Sepúlveda Hassell, A.C.S.W.

Within the Mexican American population, Mexican American elderly constitute a subgroup worthy of special consideration. Throughout the last decade considerable attention has been focused upon the nature of the difficulties encountered by seniors. Much of the research, writing and media coverage on this topic, however, has ignored the unique circumstances of minority elderly. This article briefly recounts the societal circumstances in which Mexican American elderly generally exist and subsequent implications for the delivery of mental health services to this group. Previous research findings and issues regarding responsiveness to and use of mental health and social services by the Mexican American aged are considered. Finally, the designation of the elderly as a target population in both the current and imminent federal legislation for community mental health services (PL 94-63 and PL 96-398) is discussed vis-a-vis the Mexican American aged.

Status of the Mexican American Elderly

The elderly experience multiple and pervasive physical and social stresses that effect their mental status. Social isolation, substandard housing, inaccessible or expensive public transportation, and lack of health facilities are difficulties faced by many elderly. All of these problems are compounded by social, cultural and linguistic barriers for the older Mexican American who often maintains traditional Mexican cultural values and who may not speak English fluently.

Although the cohort of individuals age 65 and over is the fastest growing age group in the United States, the Mexican American elderly make up a disproportionately small percentage of the aged population in the United States. In Texas, only 4.72 percent of the Mexican

American population is age 65 or older, an extremely low figure in comparison to the elderly in other ethnic groups. Eribes (1979) indicates that 10 percent of the national population is made up of elderly. National elderly population averages for other minority groups are 7.0 percent Asian, 7.0 percent Black, and 5.7 percent Native American (Eribes, 1979). The underrepresentation of Mexican Americans in the national aged population is evident in that only 3.9 percent of Mexican-origin women are 65 years and over compared to 12.5 percent of women not of Spanish-origin (U.S. Bureau of the Census, 1980). With the present life expectancy ranging from 61.3 to 63.0 years for male Mexican Americans, the average Mexican American man will not live to collect Social Security retirement payments, the revenues for which are disproportionately collected from low income employment groups in which the Mexican American male is often included (Eribes, 1979). The stresses being experienced by older Mexican Americans are numerous and varied, and are likely to be linked directly or indirectly to their higher mortality level.

The economic plight of the group is described by Eribes:

The Mexican American clearly represents a substantial segment of this country's invisible elderly; a subgroup whose economic status is pathetic and whose social conditions are alarming. (Eribes, 1979, p. 99)

This somber evaluation is justified, for in the state of Texas, the proportion of Mexican American elderly in poverty is approximately half (49.2 percent) of the aged ethnic population (Eribes, 1979). The low socioeconomic level of this group is related to the limited educational resources previously available to older Mexican Americans. Only 7.0 percent of Mexican American elderly have completed high school, compared to the 28 percent of Anglo elderly who are high school graduates (Torres-Gil, 1978). The lack of previous formal educational experience by the majority of Mexican American elderly compounds the difficulties experienced by this group in interactions with the complicated network of available social services.

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The extent to which the Mexican American aged are being served by the available systems of social services is difficult to ascertain due to the lack of accurate data. Previous census tabulations have been heavily criticized for failing to accurately identify the number of Mexican American elderly residents. For example, Mexican American elderly with higher levels of education, greater residential stability, documented status, bilingual ability, and willingness to interact with elements of the federal government were more likely to be sampled, thus possibly distorting the actual demographic profile of this population (Bell, Kasschau & Zellman, 1976). The Bureau of the Census has acknowledged as much as a 38 percent undercount of Mexican Americans in the 1970 Census (Valle, 1978).

Assessment of the level of Mexican American participation in federally-funded benefit and services programs for the aged are hampered by the same data deficiencies. The usage of services by a group cannot be accurately assessed if the number of recipients is not compared to accurate population counts. Initial research findings indicate that Mexican Americans participate in Social Security programs at levels equal to Blacks and Chinese Americans, but less than Anglo and Japanese Americans. The proportion of Mexican Americans receiving public assistance was found to be higher than for the other population groups (Bell, Kasschau & Zellman, 1976). These findings, however, must be cautiously accepted due to the flaws in census data collection discussed.

Health and Mental Health Status of Elderly Mexican Americans

Research findings on the incidence and nature of the health and/or mental health needs of Mexican American aged are either limited or nonexistent. According to Butler and Lewis (1977), the state of one's physical health is a critical factor in adjustment to old age. As the mental health status of Mexican American elders is likely to be influenced by their physical health status, the health needs of the population are of considerable importance. Newton (1980) reports that present research literature is in unanimous agreement that the physical health status of Mexican Americans is generally much poorer than that of non-minority elderly. Preliminary research efforts to assess the group's utilization of medical services indicate that aged Mexican Americans residing in California visited physicians an average of 2.3 times per year compared to 5.6 visits for Anglo seniors. The Mexican Americans were hospitalized at a rate of 47 per 1000 compared to 75 per 1000 for Anglos (Bell, Kasschau & Zellman, 1976). Although these utilization differentials may reflect the preferences of Mexican Americans for alternative systems of health care, they may also reflect the limited economic resources of the Mexican American elderly and an aversion to use of Anglo-oriented services that pose barriers related to language, culture, location, transportation and depersonalization of services.

The absence of comprehensive data on the Mexican American elders' need for mental health services and their use of available services results in many unanswered questions regarding the mental health status of this population. The likelihood of a high prevalence of mental health problems among this group is evident if one considers that the physical and economic vulnerabilities experienced by the Mexican American elderly are compounded by the racism and nonsupportive nature of the many social systems that affect the lives of most minority individuals. The President's Commission on Mental Health notes that the older minority woman faces the greatest risk in our society in psychological, social and economic terms (Report of the Special Population Subpanel on Mental Health of Women, 1978).

Social service and mental health providers may dismiss the needs of the Mexican American elderly by erroneously assuming that the extended family functions as a support system able to meet the physical and emotional needs of the aged. Many Mexican American elderly are still part of a strong familial support network that respects the aged and delegates important familial functions to them (Keefe, Padilla & Carlos, 1979; Sotomayor, 1973). Nonetheless, Penalosa (1966), Maldonado (1975) and Velez (1978) argue that this traditional arrangement has been affected by the mobility patterns of younger Mexican Americans and the urbanization process of the once predominantly rural Mexican American population. The conflicting research findings clearly indicate that the Mexican American aged are not a homogeneous group, and that individual circumstances determine the need for supportive social services and mental health treatment.

The attitudes among this group toward receiving services also vary. Numerous studies have documented the preference of the Mexican American elderly for familial rather than extra-familial support (Carp, 1969; McConnel & Davis 1977; Ragan & Simonin, 1977; Sotomayor, 1973). Nevertheless, even on this issue authors report finding different attitudes among the Mexican American aged. For example, Crouch's West Texas study (1972) indicates that 61 percent of the Mexican American elderly sampled believe that the family is not obligated to support their older members. Newton (1980) reports that two other studies in California urban areas conducted by Bengston (1976) and Valle and Mendoza (1978) found that the majority of the Mexican American seniors studied did not want to become burdens. From these studies, it is apparent that many Mexican American elderly are willing to receive assistance and may, in fact, be exclusively dependent on outside sources of social and mental health support services.

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ELDERLY

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Social Policy Issues and the Delivery of Services

Services for the elderly are earmarked in PL 94-63 as one of the twelve essential service components to be offered by community mental health centers (CMHCs). Based upon the limited research available, the extent to which these services have reached the elderly is questionable. A study of eight CMHCs' services for the elderly found that:

The services provided are largely of a clinical nature to those who seek out the center for help, and that there was little emphasis on programs oriented to those elderly in the community who are either receiving care in other community-based facilities (e.g., nursing homes, homes for aged, etc.) or are reluctant or unable to come to the CMHC facility, or are unaware of the availability of the center. (Redick, 1974, p. 7)

The services available to Texas elderly from the state's CMHCs vary considerably across centers. While some CMHCs have special programs for the aged, others offer no specialized services other than those available to other adult service recipients (Mental Health Research Project, 1980). The lack of specialized services for this group which particularly needs outreach, transportation assistance and supportive services undoubtedly deters the participation of many elders in need of assistance. The absence of adequate numbers of bilingual/bicultural staff, and a culturally sensitive service orientation in the available CMHC services are additional limitations affecting Mexican American seniors. Bilingual/bicultural staff capabilities are particularly important, as Bureau of the Census studies of Hispanic elderly indicate that Spanish is the preferred language of 71.9 percent of the 55-64 age group and of 85.4 percent of Hispanics 65 + years of age (Valle, 1978).

Current federal mental health legislation and policies are auspicious with regard to geriatric services. Sec. 20(a) of the Mental Health Systems Act (PL 96-398) authorizes funds for mental health services to the aged that will:

- 1) locate elderly individuals in need of mental health care,
- 2) provide for differential medical diagnostic services to distinguish between needs for mental health services and other services,
- 3) specify the need for mental health and support services for the elderly, and

- 4) provide mental health and support services to the community including the residents of nursing homes and intermediate care facilities as well as training for the personnel of such facilities.

At least 40 percent of the \$30 million authorized by the Mental Health Systems Act for services to priority population in FY 82 are to be used for projects to serve the elderly. Even if more than the minimum \$12 million dollars are made available for projects to serve the elderly, this is relatively little funding to serve a population with such great needs.

The Reagan administration is likely to maintain a supportive posture toward the mental health needs of the elderly. The Foster Grandparent Program is reportedly a pet project of Nancy Reagan's. A Reagan/Bush campaign statement of October, 1980, which was addressed to the National Mental Health Association, stated Reagan's intent to:

Support a policy based on a partnership with local government and the private sector to fulfill our responsibility to keep our intergenerational compact with older Americans:

- *provide for outreach services to meet the problem of access to needed mental health service for older Americans*
- *identify and assess the mental health needs of the elderly and provide services where gaps exist*
- *assure the availability of personnel trained to provide mental health and support services for older Americans*
- *co-ordinate existing services and programs available to serve the mentally ill elderly*
- *encourage programs for staff training for those who will work with this population group. (Reagan/Bush Committee, 1980, p. 2).*

Will the Mexican American Elderly Be Overlooked?

In the midst of the supportive ambiance at the federal level for services to the aged, it is essential that this population not be viewed as a homogeneous group without diverse needs and circumstances. The research previously cited illustrates the variability among Mexican American elderly regarding their needs for and response to human services. Social service and mental health providers must recognize that a commitment to serve Mexican American seniors entails a responsibility to plan and implement services in a culturally sensitive manner. Without bilingual/bicultural staff, outreach efforts into the *barrio*, the location of services within the Mexican American community, the incorporation of Mexican Americans at planning and policy determination levels, and an awareness of Mexican American cultural values, the services that are needed by this special segment of the Mexican American population will continue to be inappropriately defined and underserved.

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REYMUNDO RODRIGUEZ APPOINTED TO NIAAA NATIONAL ADVISORY COUNCIL

Reymundo Rodriguez, an Executive Associate of the Hogg Foundation for Mental Health, was recently designated for a four-year appointment to the National Advisory Council of the National Institute for Alcohol Abuse and Alcoholism (NIAAA), Dept. of Health & Human Services, Washington, D.C. Rodriguez has an extensive background of interest and advocacy in the area of social services which has been highlighted by such events as service on The President's Commission for Mental Health in 1977-78. In an interview with MHRP staff members, Rodriguez outlined several of the key areas he wishes to address as a council member.

As has been the case in other social service areas, NIAAA and the programs it funds have not been sufficiently effective in meeting the needs of Hispanics. Indeed, the most effective programs in the area of alcoholism have been those of the Alcoholics Anonymous, and even in these programs Hispanics have been poorly represented. Whether Hispanics historically have not participated in these programs due to language barriers (most meetings being held in English) or sociocultural barriers (meetings being held in Anglo middle-class neighborhoods) is not clear, but the Hispanic's need for services remains and must be addressed. According to Rodriguez, efforts must continue to focus on developing programs that are linguistically and culturally appropriate to the needs of the Hispanic population. Rodriguez notes that a better balance must be achieved between future alcoholism research in the biomedical and biosocial areas. The biosocial area, which focuses on the socioenvironmental and cultural issues related to alcoholism and its prevention, has not been explored as extensively as the biomedical area.

Rodriguez notes that despite the urgent need for services among Hispanics, the personnel resources necessary to meet these needs are not available. Hispanics trained in the social services are few in number and are not sufficiently represented in key decision-making positions in alcoholism service programs and NIAAA. In addition, Rodriguez feels that there is not sufficient attention being given to enlarging the pool of trained Hispanics by assisting and recruiting students as early as junior high school into the fields of social services.

In Rodriguez's opinion, the three issues of research, services and personnel resources are interrelated, and improvements in all three areas will be necessary if Hispanics are to begin to be equitably served. A fourth crucial and timely issue is funding. Rodriguez indicated that NIAAA is scheduled to experience budget cuts of approximately 50 million dollars which would have been used to support formula grants for the state authorities.



Reymundo Rodriguez

The anticipated fiscal cutbacks will affect the Texas Commission on Alcoholism's service delivery capabilities, unless the state of Texas provides the additional funds to alcoholism services. Rodriguez stated that such a rollback of funds will have an enormous effect on services, particularly to youth, minorities and women. Rodriguez hopes to focus his energies as a council member in these four crucial areas of concern with regard to Hispanics: research, services, personnel and funding. Rodriguez plans to involve himself, as time permits, in an outreach capacity with groups and organizations attempting to develop or maintain alcoholism service projects. By doing so, he hopes to serve as a communications liaison, and access crucial information from the new administration to local service programs.

GRACIAS STUART

The staff of the Intercultural Development Research Association's Mental Health Research Project (MHRP) wish to express our gratitude to Mr. Stuart Fisher, recently retired Director of Planning of the Texas Department of Mental Health and Mental Retardation (TDMHMR). During the past two years' activities of the MHRP, we have been fortunate to have Mr. Fisher as our liaison with TDMHMR. Mr. Fisher's cooperation, assistance and encouragement during this period greatly facilitated the MHRP's work. We wish him well in his retirement and hope that he continues his advocacy endeavors in mental health.

THE MEXICAN AMERICAN PARAPROFESSIONAL: STAFFING RESOURCE FOR CURRENT SERVICE NEEDS

by Rosa Maria Moreno

The staff of a community mental health center (CMHC) can be key elements to the acceptance and effectiveness of the center, as viewed by the community it serves. The center staff, formally and informally, shape both the philosophical orientation of service delivery and the role the center will play in the network of human services of the community. In addition, the perceived competency, understanding and responsiveness of staff greatly affect clients' utilization of and satisfaction with services.

In the case of the Mexican American client, numerous studies have pointed to the importance of bilingual/bicultural staff who understand both the needs and the socio-cultural milieu of the client (Barrera, 1978; Casas & Keefe, 1978; Marcus, 1980). Despite this information, the problem of insufficient numbers of bilingual/bicultural personnel continues to exist in most community mental health centers. One of the primary issues concerning the need for bilingual/bicultural staff is whether current and future needs can be met by increasing the numbers of Mexican American professionals and Mexican American paraprofessionals. Relative advantages of professional versus paraprofessional¹ staff and the role that each should fill are currently a source of much debate.

NATIONAL AND STATE IMPERATIVES

Culturally and Linguistically Appropriate Staff

The National Standards for Community Mental Health Centers, which were presented to the Congress in January 1977 by the Secretary of Health, Education and Welfare, give added support to the importance of utilizing culturally and linguistically appropriate staff in providing services to the Mexican American population (National Institute of Mental Health, 1977). In addressing the needs of cultural and linguistic minorities, the National Standards state that CMHCs shall minimize social and cultural barriers for the recipients of mental health services "by hiring staff in direct services who are familiar with the cultural sub-groups of the community, and by providing written materials on policies and

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¹Although various terms have been used to differentiate professionals from other mental health workers — paraprofessional, non-professional, sub-professional, mental health associates, and more specific job titles — there are two generally understood meanings for these terms. One includes in its definition of paraprofessionals or non-professionals anyone who does not possess at least a bachelor's degree in a mental health-related field, such as psychology or social work. Another definition commonly used, however, defines a mental health professional as a psychologist or counselor with either an M.A. or Ph.D., an M.S.W. in clinical social work, or a physician with a psychiatric residency. Others would be considered nonprofessional or paraprofessional (Karlsruher, 1974). The major difference in the two definitions is in the placement of bachelor-level individuals in the categories of paraprofessional or professional. Each definition excludes bachelor-level individuals, resigning them to the other category.

In this article, those mental health workers having bachelor-level training are not considered in either the paraprofessional or professional category, but rather are left for separate analysis at a later date.

services in languages appropriate to the area being served" (NIMH, 1977, p. 38). The standards also require that CMHCs in areas with "major population subgroups" utilize bilingual/bicultural staff in direct service delivery and that service staff be as "representative as possible of the racial, ethnic, and cultural characteristics of the catchment area" (NIMH, 1977, p. 38).

It is noteworthy that the state of Texas does not address this issue in the standards developed for CMHCs by the Texas Department of Mental Health and Mental Retardation. The standards do, however, make reference to nondiscriminatory hiring and promotion procedures, and the development of written affirmative action plans by CHMCs (TDMHMR, 1979).

The Mental Health Systems Act (PL 96-398, Sec. 307(b)(4), enacted October 7, 1980, by the 96th Congress, maintains the requirement that funding applications by CMHCs and other entities under the Act serving a sizeable non-English speaking population have:

developed a plan and made arrangements responsive to the needs of such population for providing services to the extent practicable in the language and cultural context most appropriate to such individuals, and

identified an individual on its staff who is fluent in both that language and English and whose responsibilities shall include providing guidance to such individuals and to appropriate staff members with respect to cultural sensitivity and bridging linguistic and cultural differences.

Qualified Staff

Both national and state standards are vague about the type and level of training required of personnel involved in providing community mental health services. The National Standards (NIMH, 1977) state that written position descriptions for all CMHC staff should be developed and should include duties and qualifications. In addition, "those tasks which are restricted by law to specific disciplines shall be performed only by qualified individuals," and "jobs shall be performed only by staff qualified for that job" (NIMH, 1977, p. 30). A standard is also specified that centers "shall provide for supervised practical experience, education and training to increase the skill level of staff members," which will be based on individualized staff development plans (NIMH, 1977, p. 33).

State standards for community mental health centers are very general in addressing the staffing composition of centers. Texas standards state, among other things, that CMHCs should have job descriptions for each position describing duties, responsibilities and qualifications; procedures to ensure that staff possess the skills, attitudes, and knowledge needed; and a staff development program (TDMHMR, 1979).

The Mental Health Systems Act of 1980 simply states that "(t)he mental health care of every patient of a center

shall be under the supervision of a member of the professional staff of the center" (PL 96-398, Sec. 101(b)(3), 1980).

Both the national and state standards are general guidelines and, at this point, are difficult to enforce. In addition, there is vague definition of "professional staff," "qualified staff," "responsive to the needs of," and other such phrases. However, the standards do point strongly to the need to employ staff in direct services who are appropriate for the clientele to be served — appropriate in that they are familiar with the language and culture of the subgroups within the area and also reflect the racial, ethnic and cultural characteristics of the community served. Another issue raised, by both state and national standards, is that of *appropriate personnel* in terms of the skills and knowledge possessed. The primary need addressed by these standards is for Mexican American professional staff who can provide therapeutic services. However, this has not been accomplished and indeed seems unlikely in the future, unless more concrete and enforceable standards are developed.

Mexican American Mental Health Professionals

There is no doubt that Hispanic mental health professionals are a scarce commodity; Mexican American professionals are even fewer in number (Olmedo & Lopez; 1977). In 1977, there were only 85 Spanish-surnamed psychiatrists residing in the United States, or approximately .54 percent of the total membership of the American Psychiatric Association (Ruiz, 1971). In 1976, there were only 43 Mexican American psychiatrists in training in the U.S. (Martinez, 1977). This does not offer much hope that there will soon be a substantial increase in the number of Mexican American psychiatrists.

In 1975, Hispanics made up approximately 2.0 percent of the total Ph.D. psychology students in the United States, with Mexican Americans comprising a portion of that figure. Based on such factors as minority graduate school enrollments and scholarship/fellowship resources available, it appears that this percentage has reached a peak and is declining (Stang & Peele, 1977).

The greatest representation of Hispanics in mental health fields is in the social work profession, although Mexican American representation is still far from proportionate to the population. The Council of Social Work Education statistics show that Hispanic full-time students in master's level programs ranged from 2.7 percent to 4.6 percent of the total national enrollments during the period from 1969 to 1975, with the peak in 1972. In social work Ph.D. or D.S.W. programs, Hispanics comprised 5.5 percent of the total in 1974 and 4.5 percent in 1975 (Miller, 1977).

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In the psychiatric nursing profession, Hispanics are also severely underrepresented. Although exact figures are not available, Murillo-Rohde estimates that there are no more than 10-12 Hispanics in the U.S. with master's level degrees (Murillo-Rohde, 1977).

Not surprisingly, the picture in Texas exhibits a very similar pattern, with Mexican American underrepresentation existing in the four major mental health fields mentioned above (Price, 1980).

Despite the acknowledged need for more Mexican American mental health professionals, the future presents a dismal picture for supplying the minimal levels of demand. In looking for an alternative source of bilingual/bicultural staff, the focus of personnel recruitment has often turned to the Mexican American paraprofessional. This is supported by research findings of the Mental Health Research Project which demonstrate that the majority of Mexican Americans currently employed in mental health in Texas are found in the paraprofessional occupational categories. Fiedler's analysis (1979) of staffing patterns at Texas CMHCs in 1978 reveals that in the combined personnel categories of administrators and professionals, 75 percent were Anglo, 12 percent were Hispanic, and the remaining 13 percent were professionals of other racial/ethnic groupings. In contrast, in the paraprofessional category, only 47 percent were Anglo and 21 percent were Hispanic. In order to understand this phenomenon, one needs to examine the development of increased reliance on paraprofessional staff in the mental health service delivery system in this country.

The Paraprofessional Movement and Community Mental Health

Nationally, the ratio of professionals to paraprofessionals in mental health facilities is 60:40 (Kuramoto, 1977). The Report to the President's Commission on Mental Health from the Special Populations Sub-Task Panel on Mental Health of Hispanic Americans (1978), points out that "Hispanics are served more often by paraprofessionals rather than professionals" and that paraprofessionals "do not have the training to provide the quality of service which the professional mental health worker can provide" (*Report of the Special Populations Sub-Task Panel on Mental Health of Hispanic Americans*, 1978, p. 3). Kuramoto (1977) refers to this as a "dual system of care," in which the poor and minorities are receiving a differential type and quality of care, since they are more often treated by paraprofessional staff than are Anglos.

The contributions of paraprofessionals to the mental

health delivery system have been welcomed by some but seen as a problem by others. In order to understand the controversy surrounding the use of paraprofessionals in mental health settings, one must understand the reasons for their growing use, the role they play in service delivery, and the reservations researchers and practitioners have regarding them.

The shift in emphasis from professional to paraprofessional personnel is partially an outgrowth of the civil rights and community services movements of the 1960s. In an effort to provide human services which were more relevant to minorities and communities, indigenous workers were hired who were more similar to the client population in terms of ethnicity, social class, culture, language and background experiences. This ideology, coupled with the lower personnel cost entailed, was compatible with the concepts of community mental health. For that reason, and others, the number of paraprofessionals employed at CMHCs began to increase.

The acceptance of paraprofessionals in mental health settings was affected by the shortage of professionals, combined with the increasing demand for health centers and other human services. The uneven distribution of mental health professionals, then and now, has served as a rationale for employing paraprofessionals to carry the load of service delivery (Sobey, 1970). By utilizing paraprofessionals, the mental health system would not have to wait the years or decades it might take to train adequate numbers of professionals; more people would be served if the preoccupation with professionalism and credentialing could be supplanted by teaching indigenous workers and other nonprofessionals through on-the-job training. One of the counter-arguments, related to graduate and post-graduate training, was that if paraprofessionals were allowed to perform the same tasks and functions as professionals, what relevance or need would there be for graduate and post-graduate training? Professionalism was questioned, creating not a small amount of paranoia among some professionals (Cooper, 1972). The primary issues raised as a result of the shift to more paraprofessional involvement in mental health services were: 1) Are professionals themselves currently providing adequate and appropriate services to minorities and the poor? 2) Is the training that professionals bring with them for treating clients in community mental health settings adequate or appropriate? and 3) Can paraprofessionals adequately perform or be trained to perform effectively in the CMHC? (Cooper, 1972).

The movement for paraprofessional involvement in the delivery of mental health services also became embroiled in the controversy between proponents of the medical model versus the social service orientation in community mental health. The medical model, emphasizing clinical services and professionalism, is said to be reviving after some setbacks in the 60s and 70s (Kuramoto, 1977). One of the primary reasons for this resurgence is economic — as resources become more limited, it is

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expected that a greater emphasis will be placed on clinical services over preventive care, consultation and education, and community outreach services. Clinical services are usually more amenable to such funding mechanisms as third-party payments, which are limited to services of professionals such as psychiatrists and psychologists.

Before one can begin to evaluate the quality of service provided by paraprofessionals, it is important to describe the role this group has played in the CMHC system. Paraprofessional roles seem to vary considerably from center to center. The three major functions that have been identified as those most commonly assigned to paraprofessionals are: 1) a strictly supportive role, associated with performance of menial administrative or client-related tasks, aimed at freeing professionals to spend more time providing therapeutic services to clients; 2) a community-oriented role, such as connecting clients with other agencies, outreach, and follow-up of clients; and 3) a therapeutic role, in which the paraprofessional is seen as doing many of the same types of direct client services as provided by the professional staff (Alley, 1976). For Mexican American paraprofessionals, the latter two roles have been more prevalent because of the language and cultural barriers that often exist between clients and most professionals.

Despite the pivotal responsibilities assigned to many paraprofessionals, their training, supervision and participation in decision-making is minimal. In a study of 22 CMHCs in Michigan, Cherniss (1978) found that staff, especially paraprofessionals, with the most direct involvement in working with clients also had the least input in the decision-making process that affected their work and the delivery of services.

Another major reservation which has been expressed in the literature is that the training of paraprofessionals is not adequate for the roles and duties they are asked to perform. In fact, it seems that the "amount of time spent in patient care seems to be negatively related to the extent of training" (Glasscote & Gudeman, 1969, p. 164). The implications for the kind of care received by Mexican Americans are numerous. In addition, the training needs of the limited number of Mexican American staff in community mental health centers are largely ignored; very little emphasis is placed on the training of Anglo professionals and paraprofessionals to enhance their abilities and cultural/linguistic knowledge base for serving Mexican American clients (Brusco & Ramirez, 1979).

Training needed by paraprofessional workers includes familiarization with academic principles in the fields of psychology, social work and community mental health; supervisory experience in interagency coordination, policy and administrative requirements; and direct client services. Whether this can be accomplished through in-service training alone or whether it requires an associate degree has not been substantiated. As far back as 1966, NIMH initiated attempts to develop training

programs for paraprofessionals. One avenue taken was to support a two-year program at Purdue University (Baker, 1975) which combined general liberal arts courses, mental health-related courses (child development, social welfare, etc.), a specialized mental health curriculum, and field experience. NIMH also initiated a New Careers Program to provide training opportunities for minorities and the poor, and at the same time to incorporate indigenous paraprofessionals into community mental health centers. Almost 20 percent of the 351 New Careers trainees were Mexican American (Barrera, 1978).

Effectiveness of Paraprofessionals

Probably of most concern is the effectiveness of paraprofessionals. There seems to be considerable descriptive literature regarding the effectiveness of paraprofessionals, especially in therapeutic roles (Sobey, 1970; Karlsruher, 1974), but little empirical research has been conducted regarding this issue. Andrade & Burstein's study (1973) is one of the few that actually deals with the effectiveness of Mexican American paraprofessionals and their impact upon the Mexican American community.

One of the major problems with assessing effectiveness is, of course, identifying the multiple roles that paraprofessionals often assume. The effectiveness of mental health services is still a difficult-to-define, hard-to-measure element. Determining effectiveness in a bilingual/bicultural setting is an even more complex issue, due to the limited number of such programs, few of which have been evaluated.

A study by Carkhuff and Truax (1965) indicates that the performance of the paraprofessional counselor, when measured in terms of behavioral improvement of the client, is at or near the level of professional counselor effectiveness. The effectiveness of paraprofessionals is not easily explained. Carkhuff points to the selection process of paraprofessionals, which usually chooses persons with high degrees of empathy, warmth and caring (Brown, 1974). Others have pointed out that paraprofessionals are seen more in the role of a helper in tapping community resources or mediating with other agencies. Still another reason given for their effectiveness has been the paraprofessional's ability to cut through an imposed social distance between client and therapist, usually because the paraprofessional is of the same social class and understands the client's environment. In the case of the Mexican American and other minority groups, paraprofessionals with an understanding of the culture, language, and life experiences of the client would tend to have an advantage in providing services. However, Andrade (1973) presents

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empirical data that although Mexican American clients may see themselves as more similar or "socially congruent" to Mexican American paraprofessionals than professionals, the same clients indicate that Mexican American professionals are more understanding and more helpful than their paraprofessional counterparts. Even though Mexican American paraprofessionals may certainly make an important contribution in the mental health setting, this study at least seems to re-emphasize the need for hiring more Mexican American professionals.

Despite isolated studies which indicate apparent effectiveness, it is difficult to assess to what extent the role of the paraprofessional should grow. The question of which type of setting, type of client, and type of client problem can most effectively be addressed by paraprofessionals has been superficially explored. What becomes clear in all of this uncertainty is that if little is known about paraprofessionals' effectiveness in providing services to the general population, even less is known about their impact on linguistically and culturally different population subgroups.

Recommendations

A number of recommendations and alternatives concerning the paraprofessional/professional dilemma in community mental health merit serious consideration. Use of the team approach has gained much attention, whereby paraprofessionals are teamed with mental health professionals in planning and implementing treatment services to clients. However, of utmost importance is the need for a clearer definition of the role of the paraprofessional and the level of training and supervision needed to provide quality services to clients.

If the national and state standards for CMHCs are to be taken seriously, it is evident that a two-pronged approach is needed, such as suggested in Figure 1, in order to meet the needs of the Mexican American client. However, to assess the current level and quality of services being provided to Mexican Americans, some of the questions raised regarding paraprofessionals in community mental health need to be resolved. At this point, most of the reservations and rationales about the use of the paraprofessional are in the realm of assertions, with little evidence to prove or disprove them.

Not to be dismissed is the importance of training, both in professional schools and in the staff development programs of mental health facilities, of the Anglo professional and paraprofessional to equip him or her to understand values and socio-cultural experiences of the

RECOMMENDATIONS FOR INCREASING LEVELS OF BILINGUAL/BICULTURAL STAFF

Figure 1

Increase Number of Mexican American Professionals

- Increase rates of high school completion by Mexican American students.
- Increase career awareness & proper counseling for mental health professions in grade school and high school.
- Increase recruitment and admissions of Hispanics into colleges and professional graduate programs related to mental health.
- Increase financial support for Hispanic students while in advanced degree programs.
- Increase financial incentives to reduce manpower shortage in practice areas with need for Mexican American professionals.

Strengthen Services Provided by Mexican American Paraprofessionals

- Clarify role responsibilities and standards for paraprofessionals.
- Strengthen in-service training and increase incentives for continuing education.
- Increase training programs in colleges & universities for upgrading skills of paraprofessionals.
- Provide financial support for training opportunities, both for continuing education and in-service programs.

Mexican American community and subgroups within it. It is essential that these persons be bilingual, since the use of interpreters or intermediaries is not only ineffective, but also time-consuming, difficult on both client and therapist(s), and may lead to misinterpretations and inaccuracies in the treatment process (Kline, et al., 1977; Marcos, 1973; Edgerton & Karno, 1976).

In addition, a major focus in providing services to this special population should be to bring Mexican American professionals to a level of representation in mental health facilities more proportionate to their representation in the population, especially in those facilities where a majority of the clients are Mexican American.

At the same time, the Mexican American paraprofessional, aside from receiving training as a CMHC staff member, needs to be encouraged and supported in efforts to further his or her education, whether it be in one of the twelve Mental Health Associate degree programs in Texas, or in bachelor's degree programs in the state's colleges and universities. More active recruitment of Mexican Americans by professional schools in psychology, social work and psychiatry is needed at all levels of the educational process.

REFERENCES

- Alley, S., & Blanton, J. A study of paraprofessionals in mental health. *Community Mental Health Journal*, 1976, 12, 151-160.
- Andrade, S., & Burstein, A. Social congruence and empathy in paraprofessional and professional mental health workers. *Community Mental Health Journal*, 1973, 9, 388-397.

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Plan evidences a more specific attention to the needs of special populations for 1980-81 and a number of promising objectives. There are several issues, however, that must be kept in mind by both state agency personnel and by community advocates for special populations.

1. *Who is a member of a "special population"?* As was documented in this article, the Texas Commission on Alcoholism, like many other state and federal agencies, varies in the groups it identifies as special populations: women, youth, Blacks, Mexican Americans, Native Americans, the elderly, low-income individuals, the handicapped, victims of domestic violence, rural residents and "others." At some point, we are going to have to challenge the unceasing expansion of this pool of special target populations and the continuous dilution of planning energy and resources to address their needs. It is clear that the above groups encompass much more than 50 percent of the state's population, yet they continue to be categorized as minority groups necessitating compensatory funding. Furthermore, the most devastating effect of such an approach to services for ethnics of color is to define need categories as if there were no ethnic women, ethnic youth, ethnic elderly, handicapped ethnics, rural ethnics, etc. The data collection and planning processes must be reconceptualized in order to develop more socially sensitive and cost-effective interventions.

2. *What are the responsibilities of public agencies to ethnic communities?* There is a passive quality about the 1980-81 posture of the Texas Commission on Alcoholism that is again similar to those of other state and federal agencies. When TCA proposes objectives such as identifying funding sources and providing technical assistance to programs that wish to develop programs or reviewing applications for federal formula funding, how much agency resources are being allocated to such objectives? An aggressive and culturally appropriate outreach effort to ethnic community groups is often required to make them aware that opportunities are available; sitting back and waiting for technical assistance requests to come into one's agency is an almost certain guarantee that one will not have to spend much time in the field. In addition, TCA could take a much more assertive posture in working with regional staff to ensure that ethnic needs are addressed at that level.

3. *Why are there so few prevention programs which target Mexican Americans?* The Texas Commission on Alcoholism, like so many human service agencies, fails to recognize the important demographic factor of an ethnicity-by-age interaction: Mexican Americans are significantly younger than other populations, and their group is growing in number and proportion. Because almost half of the Mexican American population are children and adolescents, it is crucial to emphasize prevention efforts, particularly in the field of chemical substance abuse. Thus, a sizeable amount of the resources in such campaigns as that of the Fetal Alcohol Syndrome

should focus on Mexican American women. Translation of materials developed for Anglo consumers is seldom an effective means of communicating with bilingual/bicultural Mexican American consumers. Outreach programs and media campaigns should be ethnic-specific in order to ensure that Mexican American communities are impacted effectively. National corporations are recognizing this fact in their advertising strategies, particularly to promote alcohol and tobacco sales. Therefore, it seems evident that consultation with Mexican American service providers and community leaders, and increasing the number of Mexican American professional staff in the agency are essential components of developing successful prevention campaigns.

As the Texas Commission on Alcoholism proceeds with the implementation of the *Texas State Plan* in 1981, advocates for alcohol services for Mexican Americans should be supportive of the new goals and objectives it has outlined. Simultaneously, they must maintain an objective perspective, insisting that TCA be evaluated on the achievement of specific objectives and on its efforts to acknowledge the needs of Mexican Americans for much more effective alcohol abuse prevention programs, strategies and materials.

The 1980-81 *Texas State Plan for the Prevention, Treatment and Control of Alcohol Addiction and Abuse* is available for public inspection at all Texas Commission on Alcoholism area offices, listed below.

Texas Commission on Alcoholism Regional Alcoholism Offices

- Central Office: Eighth Floor, Sam Houston Building,
Austin, TX 78701 (512) 475-2577
- Area I: 1422 South Tyler, Suite 104, Amarillo, TX
79101 (806) 372-7791
- Area II: 600 Avenue H East, #104, Arlington, TX 76011
(817) 640-4124
- Area III: 1330 East 8th Street, #316, Odessa, TX 79761
(915) 332-0186
- Area IV: 105 West Riverside Drive, Suite 128, Austin,
TX 78704 (512) 475-6207
- Area V: 2472 Bolsover, #273, Houston, TX 77005
(713) 522-0735
- Area VI: 4455 South Padre Island Drive, #11, Corpus
Christi, TX 78411 (512) 855-2281
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REFERENCES

- Bell, D., Kasschau, P., & Zellman, G. *Delivering services to elderly members of minority groups: A critical review of the literature*. Santa Monica, Ca.: Rand Corporation, 1976.
- Bengston, V. L. Families, support systems, and ethnic groups: Patterns of contrast and congruence. Paper presented at the 29th Meeting of the Gerontological Society, New York, 1976.
- Butler, R. N., & Lewis, M. I. *Aging and mental health*. St. Louis: C. V. Mosby Co., 1977.
- Carp, F. M. Housing and minority group elderly. *Gerontologist*, 1969, 9, 20-24.
- Crouch, B. M. Age and institutional support. *Journal of Gerontology*, 1972, 27, 524-529.
- Eribes, R. A. The older Mexican: The invisible elderly. *Aztlan*, 1979, 10, 91-100.
- Keefe, S. E., Padilla, A. M., & Carlos, M. L. The Mexican American extended family as an emotional support system. *Human Organization*, 1979, 38, 144-152.
- McConnell, S. R., & Davis, W. J. *Social and cultural contexts of aging: Decision-maker survey report*. Los Angeles: Andrus Gerontology Center, University of Southern California, 1977.
- Maldonado, D. The Chicano aged. *Social Work*, 1975 20, 213-216.
- Mental Health Research Project. *Field Notes 1979-1981*. San Antonio: Intercultural Development Research Association, 1981.
- Newton, F. C. Issues in research and service delivery among Mexican American elderly: A concise statement with recommendations. *Gerontologist*, 1980, 20(2), 208-213.
- Peñalosa, F. The changing Mexican American in Southern California. *Sociology and Social Research*, 1966, 51, 405-417.
- Ragan, P. K., & Simonin, M. S. Social and cultural context of aging: Community survey report. Los Angeles: Andrus Gerontology Center, University of Southern California, 1977.
- Reagan/Bush Committee. Correspondence to the National Mental Health Association, Washington, D.C., October 10, 1980.
- Redick, R. W. Patterns in use of nursing homes by the aged mentally ill. Statistical Note 107. Rockville, Md.: National Institute of Mental Health Division of Biometry, 1974.
- Report of the Special Populations Subpanel on Mental Health of Women. *Task panel reports submitted to The President's Commission on Mental Health, Vol. III*. Washington, D.C.: U.S. Government Printing Office, 1978.
- Sotomayor, M. Mexican American interaction with social systems. *Social Casework*, 1972, 52, 316-324.
- Torres-Gil, F. M. Age, health and culture: An examination of health among Spanish-speaking elderly. In M. Montiel (Ed.), *Hispanic families: Critical issues for policy and programs in human services*. Washington, D.C.: National Coalition of Hispanic Mental Health and Human Service Organizations, 1978.

U.S. Bureau of the Census. A statistical portrait of women in the U.S., 1978 (Current Population Reports: Special Studies, Series P-23, No. 100). Washington, D.C.: U.S. Government Printing Office, 1980.

Valle, R. The Latino elderly: A status report. In *Policy issues concerning the minority elderly: Final report, six papers*. San Francisco: Human Resources Corporation, 1978.

Valle, R., & Mendoza, L. *The elder Latino*. San Diego: Campanile Press, 1978.

Velez, C. Youth and aging in central Mexico: One day in the life of four families of migrants. In B. G. Meyerhoff & A. Simic (Eds.), *Life's career - Aging. Cultural variations on growing old*. Beverly Hills: Sage Publications, 1978.

White House Conference on Aging. *The Spanish speaking elderly. Special Concerns Session Reports*. Washington, D.C.: United States Government Printing Office, 1971.

AN ASSESSMENT OF THE MENTAL HEALTH TREATMENT PROCESS: ELIMINATING SERVICE BARRIERS FOR MEXICAN AMERICANS

by Sharon Sepúlveda Hassell, A.C.S.W.

ABSTRACT

Federal legislation mandates the delivery of linguistically appropriate, culturally sensitive community mental health services to linguistic and cultural minority groups. The underutilization of mental health services by Mexican Americans may, however, reflect the service delivery system's lack of understanding and appreciation for the significance of linguistic and cultural variables affecting the treatment process.

The mental health intervention process, which entails the twelve essential services to be offered by community mental health centers, is studied as an interactive process involving: 1) the cultural foundations within which mental health and illness are defined, 2) the range of cultural variability of Mexican American service recipients and their service needs, 3) the culturally based attitudinal and behavioral responses of the mental health service providers to Mexican Americans, and 4) the treatment approaches utilized with Mexican American clients. Mental health literature regarding the intervention process involving Mexican American service recipients and treatment models developed for use with Mexican Americans is reviewed. A treatment team service approach that incorporates clinical professionals and indigenous paraprofessionals in the delivery of a comprehensive range of community mental health services is proposed.

An exploration of the perceptions and attitudes of Texas community mental health center administrators and providers regarding the delivery of mental health services is reported. The underrepresentation of Mexican

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- Baker, E. J., & McPheeters, H. L. Middle-level workers: Characteristics, training and utilization of mental health associates. *Community Mental Health Journal*, 1975, Monograph No. 5.
- Barrera, M., Jr. Mexican Americans and mental health service utilization. *Community Mental Health Journal*, 1978, 14(1), 35-45.
- Brusco, B. A., & Ramirez, D. G. *Proceedings of mental health and Mexican Americans. Planning for the 80s*. San Antonio: Intercultural Development Research Association, 1979.
- Carkhuff, R. R., & Truax, C. B. Lay mental health counseling: The effects of lay group counseling. *Journal of Counseling Psychology*, 1965, 29, 426-431.
- Casas, J. M., & Keefe, S. E. *Family and mental health in the Mexican American community*. Los Angeles: Spanish Speaking Mental Health Research Center, 1978.
- Cherniss, C., & Egnatios, E. Participation in decision-making by staff in community mental health programs. *American Journal of Community Psychology*, 1978, 6, 171-190.
- Cooper, S. Role diffusion - dilemmas and problems. In H. Gottesfeld, *Critical Issues of Community Mental Health*. New York: Behavioral Publications, 1972.
- Favazza, A. R. Mental health paraprofessionals: Indigenous and middle-class. *American Journal of Public Health*, 1974, 64, 907-908.
- Feldman, S. Promises, promises or community mental health services and training: Ships that pass in the night. *Community Mental Health Journal*, 1978, 14(2), 83-91.
- Fiedler, F. P. *Utilization, staffing, and community profiles*. San Antonio: Mental Health Research Project, Intercultural Development Research Association, 1979.
- Glasscote, R. M., & Gudeman, J. E. *The staff of the mental health center: A field study*. Washington, D.C.: Joint Information Service, 1969.
- Kline, F., Acosta, F. X., Austin, W., & Johnson, R. G. Subtle bias in the treatment of the Spanish speaking patient. In E. R. Padilla & A. Padilla (Eds.), *Transcultural psychiatry: An Hispanic perspective*, Monograph No. 4 of the Spanish Speaking Mental Health Research Center, 1977.
- Kuramoto, F. H. Community mental health centers at the turning point. *Social Casework*, 1977, 58, 395-400.
- Lorion, R. P. Patient and therapist variables in the treatment of low-income patients. *Psychological Bulletin*, 1974, 81, 344-354.
- Marcos, L. R. The psychiatric evaluation and psychotherapy of the Hispanic bilingual patient. *Research Bulletin: Hispanic Research Center*. Bronx, New York.
- Marcos, L. R., Alpert, M., Urcuyo, L., & Kesselman, M. The effect of interview language on the evaluation of psychopathology in Spanish-American schizophrenic patients. *American Journal of Psychiatry*, 1973, 130, 549-553.
- Martinez, C. Hispanics in psychiatry. In E. L. Olmedo & S. Lopez (Eds.), *Hispanic mental health professionals* (Monograph), 1977, 5, 7-11.
- Miller, S. Current status of Hispanic social workers. In E. L. Olmedo & S. Lopez (Eds.), *Hispanic mental health professionals*, 1977, 5, 13-21 (Monograph).
- Murillo-Rohde, I. Hispanic psychiatric nursing personnel in the United States. In E. L. Olmedo & S. Lopez (Eds.), *Hispanic mental health professionals* (Monograph), 1977, 5, 23-29.

National Institute of Mental Health. *National standards for community mental health centers. A Report to Congress by the Secretary of Health, Education and Welfare*. Rockville, Maryland: 1972.

- Price, C. S. Representation of Mexican Americans in mental health professions and graduate programs in Texas. *Newsletter of the Mental Health Research Project*, San Antonio: Intercultural Development Research Association, 1980, 2(4), 11, 14-15.
- Ruiz, R. A. Relative frequency of Americans with Spanish surnames in associations of psychology, psychiatry, and sociology. *American Psychologist*, 1971, 26, 1022-1024.
- Shemberg, K., & Keeley, S. Training undergraduates as subprofessional community mental health workers. *Teaching of Psychology*, 1976, 3, 118-121.
- Sobey, F. *The non-professional revolution in mental health*. New York: Columbia University Press, 1970.
- Stang, D., & Peele, D. The status of minorities in psychology. In E. L. Olmedo & S. Lopez (Eds.), *Hispanic mental health professionals*, (Monograph), 1977, 5, 31-42.
- Texas Department of Mental Health and Mental Retardation, Community Service Division. *Principles and standards for community mental health and mental retardation centers in Texas*, March 1978, Revised December 1979.

RIGHTS

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The advancement of patients' rights through the judicial, legislative and executive branches of federal and state government is less than a decade old. It has evolved in the midst of controversy due to the dynamics of confrontation that has marked the movement (Kopolow, 1980). The actual impact of the patients' rights movement upon the patients themselves can materialize only if the advocacy networks are able to apply the standards already in place.

This preliminary review of the literature on patients' rights has made no specific reference to minorities primarily because the searches conducted to date by project staff have failed to produce any specific reference to this subpopulation in the literature. The absence of any references on patients' rights and advocacy for Mexican Americans and other minorities may be representative of the status quo in the field. These issues will be further explored in a special edition of this newsletter on patients' rights and advocacy issues.

REFERENCES

- Barley, J. D. Rights of human service recipients: The issues, the state of the art, and the future. *Sharing*, July/August 1980, pp. 1; 3-4.
- Brown, S. B. *Memo from the director*. Rockville, Maryland: National Institute of Mental Health, 1975.

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Americans at professional levels and the limited awareness of cultural treatment factors are discussed as indicators of the community mental health system's currently limited capacity to offer culturally relevant and linguistically appropriate services to Mexican Americans. The implications of offering bilingual/bicultural community mental health services are considered.

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RIGHTS

cont. from pg. 19

Ford, S. D. *The American legal system: Its dynamics and limits*. St. Paul, Minn.: West Publishing Co., 1970.

Kopolow, L. E. Consumer demands in mental health care. *International Journal of Law and Psychology*, 1979, 2, 263-270.

Kopolow, L. E., Brands, A. B., Burton, J. L., & Ochberg, F. M. *Litigation and mental health services*. Washington, D.C.: National Institute of Mental Health, 1976.

National Institute of Mental Health. *Implementing standards to assure the rights of mental patients*. Washington, D.C.: U.S. Department of Health and Human Services, 1980.

Perlin, M. L., & Martin, R. *Workshop materials: The impact of recent mental disability litigation*. Champaign, Illinois: Research Press Company, 1980.



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NEWSLETTER OF THE MENTAL
HEALTH RESEARCH PROJECT

Vol. 3 No. 2

MENTAL HEALTH RESEARCH PROJECT SPONSORS ACTION-FOCUSED CONFERENCE

On May 1 and 2, the IDRA Mental Health Research Project (MHRP) sponsored a conference, *Mexican American Mental Health: Issues to Action*, at the Joe C. Thompson Conference Center, The University of Texas at Austin. Participants were welcomed by Dr. Jose A. Cardenas, Executive Director of IDRA, who reiterated IDRA's commitment to working for the development of equitable and effective mental health services for Mexican American children and their families.

The conference format included a comprehensive presentation of the MHRP research findings as well as four workshops that addressed the topics of utilization of services, treatment issues, planning for services, and patients' rights and advocacy. The opening and summary sessions were highlighted by the delivery of speeches by key mental health service strategists and providers. The remarks of the four principal speakers are summarized in this article.

Opening Session

During the opening session, participants were provided with an overview of the current key mental health issues at state and federal levels. John J. Kavanagh, M.D., Commissioner of the Texas Department of Mental Health and Mental Retardation (TDMHMR), summarized major problems and opportunities for Texas mental health services in the 1980s, noting that there were serious disparities to be confronted and overcome in terms of services for Mexican Americans. Commissioner Kavanagh discussed the need for system modifications, acknowledging that although the client frequently receives the blame for service delivery problems that arise, the responsibility actually lies within the system. He noted the importance of thoroughly understanding the characteristics of each Mexican American community, in that the Mexican American population is not a homogeneous totality. In closing, Commissioner Kavanagh emphasized the three goals of the TDMHMR for the 1980s: equity, quality and effectiveness.

Senator Chet Brooks discussed mental health issues from his perspective as a Texas Legislator. He urged con-

ference participants to educate themselves and their legislative representatives about the importance of mental health and other human services. Senator Brooks commented on the seriousness of the situation confronting Texas in the next decade, in that there will no longer be the large state surpluses characteristic of the past due to the effects of inflation. He outlined bills currently under consideration in the Texas Legislature that address issues of aftercare, screening, the revision of the Texas Mental Health Code, and patients' rights and advocacy. Senator Brooks emphasized the importance of constant monitoring and communication with state legislators about such issues.

Juan Ramos, Ph.D., Director of Special Mental Health Programs at the National Institute of Mental Health, provided an update on related federal activity. He emphasized that in today's time of decreased resources, creativity is crucial. Dr. Ramos pointed out that previous legislation and policy decisions emerged through the cooperative interchange of the "Iron Triangle:" the bureau director or agency head, the U.S. congressman or state legislator, and the public or constituency. He noted that the triangle's members had been somewhat neglected in the formulation of the Reagan Administration's budget recommendations, and a uniquely powerful role had been assigned to the Budget Committees with a decreased influence on the part of the Appropriation Committees. Dr. Ramos suggested that the collaborative process would reestablish itself, however, and he challenged conference participants to take a role in helping to create responsible and cost-efficient programs sensitive to the mental health needs of Mexican Americans.

Dr. Ramos also remarked that while there was great uncertainty as to the outcome of this Congressional session with respect to mental health, there are several possibilities that service providers and advocates should consider in planning for the future. One is that there may not be enough time to enact the federal legislation in the 1981 session necessary to implement the block grant program as envisioned. Another is the possibility that a separate block grant for alcohol, drug abuse and mental health services may be enacted. The third is that there appears to be growing support for the main-

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Dr. Marta Sotomayor (l) challenges conference participants to continue mental health advocacy efforts during the closing session led by David Ramirez, MHRP Principal Investigator (r).

tenance and funding of the Mental Health Systems Act. Given that many of these issues will be debated within the context of political campaigning for the 1982 Congressional and state elections, Dr. Ramos emphasized the importance of citizen involvement at the state and local levels.

Summary Session: Issues to Action

The goal of the final session of the MHRP Conference was to summarize the research findings and service delivery issues in order to focus on specific plans of action to improve mental health services in Texas for Mexican American communities in the 1980s. Marta Sotomayor, Ph.D., Acting Associate Administrator for Public Liaison, Alcohol, Drug Abuse and Mental Health Administration, Rockville, Maryland, presented an insightful and challenging concluding address.

Dr. Sotomayor offered the premise that the impact of federal funding for mental health has been minimal for Hispanics. Federal intervention on behalf of Hispanics is already so limited that it is hard to determine what will be the impact of the proposed reductions. She emphasized seven basic points.

First, the proposed reorganization of federal mental health services into a block grant mechanism severely threatens the implementation of the Mental Health Systems Act. While the Systems Act was not as comprehensive as had been hoped for following the publication of the *Report of the President's Commission on Mental Health*, the Act did place a priority on services targeted for special populations.

Second, the implication of the 25 percent cut in federal funds on top of the block grant allocation

mechanism is that special populations will be forced to compete even more dramatically than in the past. This cannot help but increase problems of cooperation and coordination among groups that are already disadvantaged in the political decision-making process. Furthermore, it is probable that state and local taxes will have to be increased to cover existing services, which may generate further negative feelings about social services.

Third, clinical training is an issue that is being especially impacted by the Reagan proposals. This adversely affects Hispanic communities because clinical services have been the primary area in which bilingual/bicultural issues have been addressed in a limited fashion. There continues to be a lack of information regarding the state of the art in curriculum development, but it is clear that there is insufficient minority faculty in all mental health areas. In addition, given the large number of minority service providers who are paraprofessionals, training and credentialing are prominent issues for Hispanics. The proposed cutback and termination of federal clinical training funds is especially troubling, in that affirmative action is an issue addressed almost exclusively by the federal government; state governments have been characterized by their lethargy or their adversarial positions.

Fourth, prevention research and evaluation remain predominant issues for Hispanics. The lack of a social science knowledge and data base with respect to Chicanos and other Hispanics continues to be a disgrace. What is needed are comprehensive, longitudinal investigations focusing on hypothesis-building.

Fifth, given the ideological flux of the United States, what is being threatened is the comprehensive, environmental approach to social problems. In addition to the problems faced by mental health programs, other crucial services are being cut or eliminated entirely, including Legal Aid services, Neighborhood Self-Help Development Programs of HUD, CETA and other

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A FEDERAL LEGISLATIVE UPDATE: IMPLICATIONS OF REAGAN'S BUDGET PROPOSALS FOR MENTAL HEALTH SERVICES, RESEARCH, AND TRAINING IN THE UNITED STATES

by Sally J. Andrade, Ph.D.

On February 18 and March 10, 1981, President Ronald Reagan outlined his new economic policy initiative to the United States Congress. Substantial changes in the federal government's role in mental health and other social services are a part of the proposed federal health support program. The Reagan Administration's proposals call for:

- 1) the incorporation of federal mental health service grant programs into a general health services block grant which would transfer mental health service funds to the states at the end of fiscal year 1981;
- 2) the phasing out of all National Institute of Mental Health extramural research relating to social problems, as well as all research training directed toward social problems research by the end of FY 1981; and
- 3) the phasing out of clinical training activities through 1982 and their total elimination by 1983.

Although there has been an extensive process of Congressional hearings to debate the proposals, it is not yet clear what the specific implications of the budget changes approved by Congress will entail. Nevertheless, a massive reorganization is underway in the funding and administration of mental health research, training and services throughout the country. The termination of federal support for research on social problems, such as the mental health effects of racial discrimination, and the newly predominant role of the State of Texas in funding of mental health services are issues of paramount concern.

Block Grants

President Reagan proposes to implement in FY 1982 four block grant programs which will distribute to the states lump sums of federal funding which had previously been made available through categorical grant programs. The four include Health Services, Preventive Health Services, Social Services, and Emergency Assistance.

The Health Services Block Grant will consolidate seventeen existing programs and is budgeted to receive approximately \$1.14 billion in 1982. The Preventive Health Services Block Grant will consolidate eleven existing programs and is to get \$260 million in 1982. The funding for the two health grant areas is expected to remain at the FY 1982 funding levels through 1985, which represents a substantial decrease in federal funding from

the FY 1981 current services, particularly in light of inflation.

The philosophy of the Reagan Administration is one of commitment to the reduction of interference in local affairs. The rationale for the block grant approach was detailed by David Stockman, director of the Office of Management and Budgets:

The block grant approach would reduce the multiplicity of rules and regulations (and hence, federal direction) that service agencies currently operate under. States would thus have greater flexibility — as well as greater responsibility for results — in providing needed services to their populations. Overlapping funding from different programs for the same services could be eliminated. States could select the service delivery agency best able to provide certain services that are now provided by direct federal grantees. The federal government would be responsible only for financially assisting the states and providing necessary research and training funding, and states would be responsible for results of the services delivered. The overall result would provide publicly financed services more effectively at lower costs to those in need. (Morris Inc., 1981, 10:6, pp. 3-4)

Thus, the President's advisors anticipate "significant savings" through the efficiency to be achieved by the implementation of the block grant program. This was the basis for the decision to reduce federal allocations for FY 1982 by about 25 percent across the board from what will be spent in the already reduced separate categorical programs of FY 1981.

One of the major concerns expressed about the proposed block grants is that their funds do not have any significant federal restrictions attached to them. The block grant monies cannot be used for cash payments to service recipients, for construction or for the purchase of land or facilities. The governor of each state would be required to develop a plan specifying the use of funds within the four block grant areas every year, including type of services and categories of individuals to be served. The grant funds must be used for provision of services that had previously been supported by the federal categorical grants (e.g., Health Services Block Grant funds must go for health services and related activities, including planning, administration, education and evaluation).

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Within these broad limits, however, a state is free to spend its block grant funds as it chooses. A state could increase or decrease funding for a particular service, or it could even eliminate all funding for a given service if its leaders saw fit. Furthermore, the states are not required to contribute the same level of funds that they previously provided as matching monies as the result of receiving federal categorical grants in the past. Thus, it is possible that the overall level of funding for health services could diminish even further. Another issue of contention is that, with the exception of immunization of children, there will be no performance standards required of the states in their expenditure of their health services block grant funds.

Other Factors in Mental Health Administration

There are additional factors beyond budgetary considerations that must be considered as one attempts to assess the impact of the budgetary reductions proposed by President Reagan. These include the Mental Health Systems Act, the federal health planning effort, and federal program staffing.

The Mental Health Systems Act

The Mental Health Systems Act was enacted by Congress on October 7, 1980, as Public Law 96-398. One of the major accomplishments of the Carter Administration, the Act grew out of the 1978 findings of the President's Commission on Mental Health which was chaired by Rosalynn Carter. The emphasis of the Systems Act was on addressing the needs of unserved and underserved populations (e.g., the chronically mentally ill, children and youth, the elderly, racial and ethnic minorities, women, the poor, and persons in rural areas) and on prevention of mental illness and the promotion of mental health.

It appears that if the Health Services Block Grant program proposed by President Reagan is approved by Congress, it would largely eliminate any possibility of implementing the Mental Health Systems Act. Many of the special populations identified in the Act as in need of specific categorical grants are not mentioned in the Block Grant. Other observers suggest, however, that the original intent of the Systems Act was to give the states substantially more control over mental health service grants for community mental health centers and that the Reagan proposals will complete the transition.

One influential Congressperson who has been sharply critical of the Reagan Administration's plan to abandon the Mental Health Systems Act is Rep. Henry Waxman. A Democrat from California, Rep. Waxman is the chair of the powerful House Energy and Commerce Committee which handles nearly all health legislation. He apparently plans to fight hard to preserve the Systems Act which he helped to enact in 1980.

Health Planning

One of the major goals of the Reagan Administration with respect to health services is that of promoting competition in the health care industry. In this respect, the President and his staff often focus on national health planning legislation as particularly negative and oppressive.

The three basic deficiencies in the current health planning program as viewed by the Reaganites are: 1) inappropriate regulation, 2) lack of effectiveness, and 3) federal usurpation of state and local responsibilities. There has been criticism of the reliance on Health Systems Agencies (HSAs) which have strong provider representation but which are not perceived as publicly accountable. The national planning guidelines are frequently viewed as the basic framework for federal regulation of the health care system.

Thus, the proposal is to phase out federal support for the entire planning program by FY 1983. The Reagan concept is that those planning initiatives which are indeed effective will be continued with non-federal funds, while the poorly performing programs will be phased out. The problem of spiraling health care costs would be overcome, then, by stimulating competition in the health care industry, and responsibilities now carried by the federal government would have to be assumed by state and local governments.

The proposed federal cap on the federal contribution to the Medicaid program and uncertainties about what will be the rules governing a newly deregulated hospital industry in a competitive marketplace are linked to nagging doubts about the proposed dismantling of the national planning effort. If federal cuts in the Medicaid program come without some reduction in service requirements, hospitals may find themselves in an even more difficult financial situation than their current one. How health care for the poor is to be financed is of particular concern.

Many mental health care providers are more worried about the repercussions of the federal cap on Medicaid than of the block grants, in that the professionals suggest that community services for the mentally ill and mental hospital services for children and the elderly will probably be cut first as states struggle to stay under the federal Medicaid ceiling.

The Mental Health Federal Bureaucracy

The organizational changes in the federal health bureaucracy are likely to be as pervasive as the revamping of the budget. The major changes will probably be at the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) and the Health Resources Administration. It is possible that ADAMHA will be eliminated, since under the proposed budget formula it is scheduled to lose almost all of its responsibilities.

There have been indications that the National Institute of Mental Health (NIMH) will be faced with a

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MHRP Research Findings Presented At Conference

One of the primary goals of the Mental Health Research Project (MHRP) Conference was the dissemination of the project's findings to the conferees in order to receive feedback and facilitate workshop discussions. Three members of the IDRA MHRP presented an overview of the project's findings with respect to community mental health center (CMHC) services for Mexican Americans in Texas. Sally J. Andrade, Ph.D., outlined the background and goals of the MHRP. In summarizing the socioeconomically disadvantaged position of Mexican Americans in Texas, Andrade noted the historical trend of underutilization of the state mental health delivery system by Mexican Americans. She stated that the IDRA Mental Health Research Project was designed in 1977 as a systemic evaluation approach to the operation of the Texas mental health service delivery system and, in particular, of the CMHCs, which were originally conceptualized as part of a national response to the mental health needs of the poor and of minorities. The goal of the MHRP has been to produce social policy research with the long-range objective of improving human service delivery systems, in particular that of mental health, for Mexican American residents of Texas.

David G. Ramirez and Sharon Sepulveda-Hassell, A.C.S.W., presented specific findings with respect to:

CMHC service utilization patterns, with breakdowns by ethnicity and age, as well as exploring potentially different rates according to need;

treatment modalities, which involved a review of research and an analysis of data regarding representation of Mexican American clients in different treatment categories and in differing intensities of treatment modalities at the CMHCs;

staffing patterns related to differential mixes of professionals and paraprofessionals and ethnic and sex breakdowns from EEO data on the TDMHMR system;

governance patterns, in terms of ethnic, sex and profession breakdowns of CMHC governing boards and advisory committees;

the financial allocation process for CMHC budgets and an analysis of service programs in terms of their cultural or linguistic focus;

location of CMHCs in metropolitan census tracts, catchment areas and potential impact areas; and

the planning process, through an assessment of CMHC plans and health system agency (HSA) plans with reference to culturally and linguistically

specific programs designed for Mexican Americans and through interviews with CMHC planners.

In addition, Ramirez and Sepulveda-Hassell outlined work in progress by the MHRP staff in the areas of patients' rights and advocacy, alternative models of culturally targeted programs, and the responsiveness by institutions of higher education to the need for training bilingual/bicultural clinicians, administrators and researchers.

Andrade concluded the session by discussing the implications of recent federal policy changes in relation to the MHRP findings. She summarized the proposed budgetary reorganization and financial cuts of the Reagan Administration as they affect mental health and substance abuse issues. She also suggested that in spite of the pervasive gloom among bilingual/bicultural service providers, trainers and researchers, there would be opportunities for creative individuals and advocacy groups to achieve positive change if they could identify and concentrate on their major goals. National issues which have consistently emerged in mental health planning will persist at the state level. Those particularly relevant to Texas include:

- the shift of population from the Northeast to the Sun Belt region, and the significant population growth of Texas;
- the need for services for children, youth and families;
- health promotion and primary prevention;
- containment of health costs;
- patients' rights and program accountability to clients; and
- bilingual personnel capable of working with a variety of cultural groups.

Andrade noted that a significant achievement of the IDRA Mental Health Research Project has been the movement of Mexican American mental health issues out of the realm of emotional argument and into the realm of empirical data. She proposed that the major challenge for advocates of quality mental health services for Mexican Americans has been to identify their resources at the local and regional levels and to participate energetically in the development of a new statewide mental health agenda focusing on the design and implementation of innovative institutional responses to community needs. In reiterating Commissioner Kavanagh's closing remarks about TDMHMR's commitment to equity, quality and effectiveness, Andrade urged the development of new alliances and coalitions. "The challenge is based in our struggle to respect our diversity even as we affirm our unity of purpose."

TEXAS LEGISLATIVE RESPONSE TO MENTAL HEALTH ISSUES

by Rosa Maria Moreno

The 67th session of the Texas Legislature has completed its work on over 4200 bills and resolutions proposed since its commencement in January of this year. Before the session closed at midnight on June 1, 1981, the state's lawmakers considered and agreed upon a new redistricting plan for the state's representative and senatorial districts. Legislators passed the appropriations measures which will fund state government, various state agencies and the educational and human services programs to be provided by the state in the next biennium, fiscal years 1982-83.

Mental health legislation considered in this session included proposals addressing the issues of the continuity of care, confidentiality of patient records, an internal system of advocacy in the state's mental hospitals, and a study of the Texas Mental Health Code. Another topic of debate was the need for the reorganization of the central administration of the Texas Department of Mental Health and Mental Retardation (TDMHMR). Of these issues, only continuity of care legislation (S.B. 791) was approved by the Legislature.

One of the most controversial issues, however, was the level of funding for the TDMHMR, especially the impact that such funding will have on the community mental health programs of Texas. The appropriations process took place this session against the backdrop of debate on federal budgetary proposals made by the Reagan Administration. Although funding cutbacks and consolidation of mental health funding within an overall Health Services Block Grant to the states are expected to be the outcome of Congressional debate, the Texas Legislature in its budget deliberations did not have at its disposal any specific information regarding the extent and method of implementation of these proposals. In an effort to maintain some control over the use of the block grant monies for human services which will most likely be channeled through the Governor, the Texas Legislature included several riders to the appropriations bills which address the state legislature's role in the allocation and distribution of the block grant funds.

Background

A number of the proposals brought before the Texas Legislature this session can be attributed to the efforts of the Special Committee on the Delivery of Human Services (Senate 67 Committee), as well as to the work of a number of mental health advocacy groups.

The Senate 67 Committee was created through Senate Resolution 67, adopted on July 26, 1978, by the Second Called Session of the 65th Legislature of Texas. The committee of twelve, appointed by Lieutenant Governor William Hobby, was charged with the responsibility of reviewing the human services delivery system in Texas and analyzing such aspects as service coordination, cost effectiveness, program effectiveness, and planning and evaluation mechanisms. It also had the task of developing recommendations and priorities to submit to the Texas Legislature to improve the current delivery systems. The committee, consisting of four State Senators and eight other citizens, presented their final recommendations in

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November 1980 in a report entitled *The Potential in the Patchwork: A Future Pattern for Human Services in Texas*.*

Among the areas addressed in the report were continuity of care, revision of the Mental Health Code, emergency procedures for psychiatric hospitalization, and professional access to patient records. Several of the Committee's recommendations dealt with management and budgetary issues, such as reorganization of TDMHMR, implementation of a uniform client information system, and service priorities for use of grant-in-aid funds. Many of these recommendations were embodied in proposed legislation which was introduced during this session. Although a number of these proposals did not meet with success, the Committee's work raised significant issues related to services for the mentally ill of Texas. The Senate 67 Committee terminated its activities at the end of the legislative session, but the recommendations of the Committee are certain to continue to receive attention from legislators and mental health administrators in the future.

Aside from the impact of the Senate 67 Committee, the TDMHMR Legislative Program for this session also found legislative sponsors in both the Senate and House. The TDMHMR Board of Trustees in its November 21, 1980 meeting approved a proposed legislative package that included, among its 27 elements, legislation concerning purchase of real property by community mental health centers (CMHCs), lease of property by TDMHMR, and flexibility in budget fund transfers. Items relating to client services were also approved, for example, proposed screening of potential clients by CMHCs, aftercare services to be provided by CMHCs to patients released from state mental hospitals, an internal advocacy system for patients in TDMHMR facilities, and privilege of confidentiality between client and professional.

The Mental Health Association of Texas, the Texas Council of Community MHMR Centers, Citizens for Human Development, and Advocacy, Inc., are among advocate groups who became involved in this session's legislative process, mainly in supporting legislation such as continuity of care proposals, revision of the Mental Health Code, and adequate funding for community mental health services. The proponents for mental health legislation in Texas, however, received only moderate support from the state's lawmakers.

The State Budget for TDMHMR

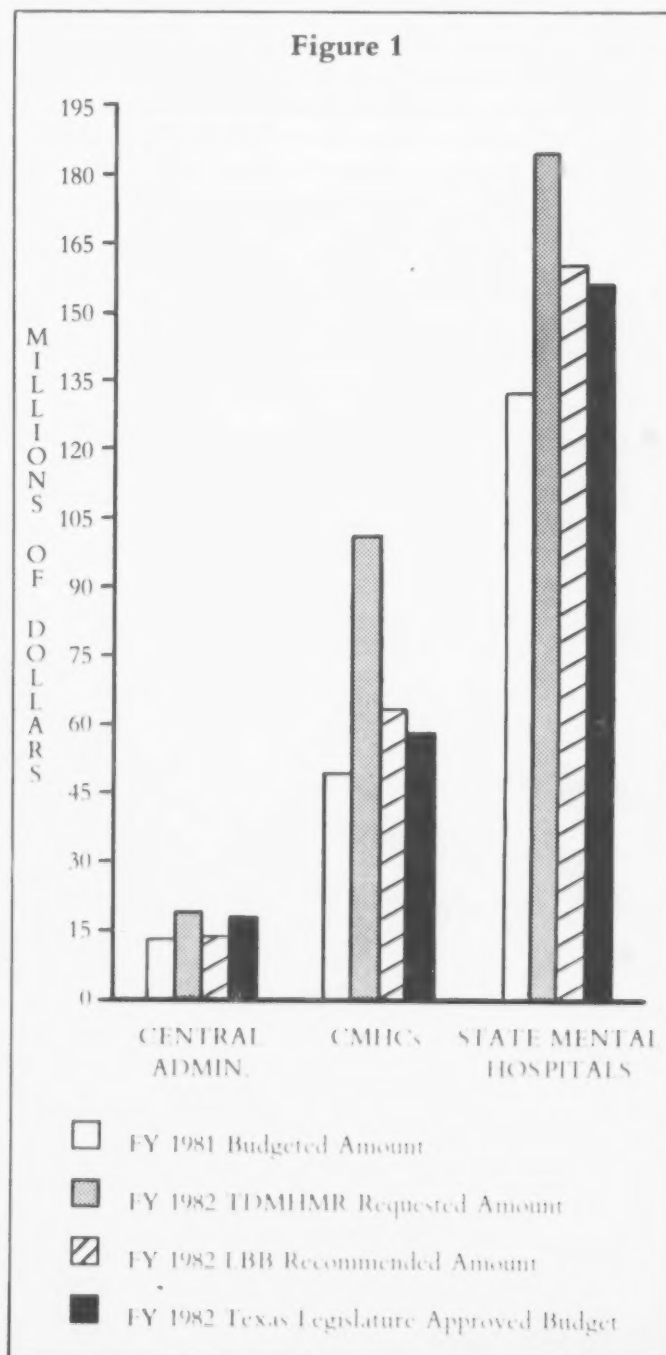
State funding for mental health services are appropriated each biennium to the TDMHMR, which operates the state mental hospitals, state schools for mental retardation, and several regional human development centers. State financial support for community mental health centers is also included in the TDMHMR budget in the form of a grants-in-aid line item appropriation. The entire TDMHMR budget is but one section of the massive appropriations bill finally approved by the House and the Senate.

*Note: Copies of this report can be obtained from the Texas Legislative Reference Library, P.O. Box 12488, Austin, Texas 78711, (512) 475-4626.

The TDMHMR submitted its request for funding for the biennium to the Legislative Budget Board (LBB), which reviews all agency budget requests and makes recommendations regarding funding levels to the Legislature.

As can be noted in Figure 1, TDMHMR requested substantial increases for fiscal year 1982 for the three budget items shown. The budget submitted by TDMHMR officials for FY 1982 included a request for \$18.8 million for the central office administration (approximately a 44% increase from FY 1981); \$185.1 million for services and operation of the state's mental hospital system (40% increase from FY

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Texas Legislative Response

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1981); and \$100.6 million for the community mental health centers grants-in-aid program (108% increase). Other items included in the budget proposed by TDMHMR brought the total budget figure request to \$688,725,196. Several factors contributed to the substantial increase requested by TDMHMR for CMHCs. Among these were the increased emphasis on deinstitutionalization of mental health services and the subsequent need for alternative community-based services; the cost of providing continuity of care services which were being sought through several bills introduced during the session; and the response to pressure brought about by legal decisions regarding the right to diagnosis, screening, and treatment in the least restrictive setting. In addition, many centers have been facing difficult financial constraints due to the expiration of federal financial support, and the inability to adequately stimulate local support and funding for programs, while at the same time facing increasing demand for services and inflationary costs.

The LBB appeared unsympathetic to these issues, recommending substantial cuts in most categories, and proposed only \$62.8 million for the CMHCs, \$159.7 million for state hospitals, and \$14.1 million for the central administration functions. The House and Senate committees charged with reviewing the TDMHMR request and the LBB recommendations also adopted a fiscally conservative posture. The Legislature, in approving the final appropriations package, allocated even less money to the CMHCs and the state mental hospitals than the amount recommended by the LBB (allocating \$58.1 million and \$156.4 million for FY 1982 respectively). The funding allocations for these two service categories for the biennium amounted to little more than attempting to meet the anticipated cost of inflation. Funding to implement the continuity of care legislation (S.B. 791), estimated by the LBB to be \$5.1 million in FY 1982, was not adequately addressed in the approved budget. In contrast, the Legislature's budget figure approved for the operation of central office administration was \$17.6 million, \$3.5 million more than recommended by the LBB. The increase was primarily the result of the approval of funds for the development of a more sophisticated computer system and the initiation through central administration of pilot programs for services to autistic children.

Another significant issue which was considered during the legislative budgetary process was the potential impact of federal budget deliberations. Although there is still a great deal of uncertainty and considerable speculation as to the outcome of congressional budget hearings, committee discussions in the U.S. Congress at this point indicate that CMHC funding appropriations for FY 1982 would receive a 25 percent cutback in funding from the FY 1981 level, with even larger cuts in following years. No definitive action has been taken regarding the exclusion of mental health programs from a Health Services Block Grant, but proponents of mental health programs at the national level are working diligently toward this end.

The concern of state legislators regarding decisions at the federal level prompted the inclusion in the final appropri-

tions package of several riders related to federal funds. One such rider provides that in the eventuality that federal block grant monies are channeled through the Governor's Office later this year, the Governor would be responsible for drawing up guidelines and a plan for the allocation of these funds. The Governor would then be required to submit the plan for review and approval of the Legislature, which would have to meet in a special called session in order to take this matter up.

Revision of the Mental Health Code

Many mental health advocates consider revision of the Texas Mental Health Code to be seriously needed. The Senate 67 Committee recommended that the Texas Legislature enact changes that would bring the Texas Code into line with current legal cases upholding the constitutional rights of the mentally ill.

The Legislature did not attempt to tackle this vital issue during this session, but rather considered the creation of an interim committee to study, formulate and recommend legislation at the next regular session of the Legislature which convenes in 1983. SCR 111, which would have created an eight member interim committee, was passed by the Senate on May 19, 1981, and referred to the House Health Services Committee. The resolution did not pass both houses, however, prior to the close of the session. The failure of the Legislature to act on this issue of growing concern only strengthens the pressure it will face next session in resolving the problems inherent in the present statutes.

Implications for Mexican American Mental Health

The legislative proposals considered by the Texas Legislature during this session will have a great impact on the mental health services provided by community mental health centers to Mexican American clients. Community centers are currently serving only a small percentage of the individuals in need of services, and utilization studies show that Mexican Americans usually are underrepresented in the served population of most CMHCs in Texas.

The financial problems which lie ahead for CMHC programs, in view of fiscal conservatism by both the state and federal government, are certainly of concern. Development of new programs and/or strengthening of existing programs in order to meet the cultural and linguistic needs of the Mexican American client may not receive the attention it deserves from mental health administrators intensely concerned about simply maintaining the current level and type of services offered. Indeed, Mexican American mental health advocates will need to closely monitor legislative and funding developments to ensure that what gains have been made in services and staffing are not jeopardized by the funding cutbacks.

The continuing need for revision of the Texas Mental Health Code should also be of great concern to Mexican American mental health advocates. Although an interim committee was not established by legislative mandate, activity is certain to take place to develop proposals for consideration in the 1983 legislative session. The Mexican American community needs to make its views and needs

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MHRP Conference

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youth programs. The marketplace orientation of the Reagan Administration is relocating the decision-making process at the state and local levels without any assurances that the needs of Hispanics and other special populations will be acknowledged and addressed.

Sixth, there is a profound need for more sophisticated conceptual and empirical work on fundamental definitions. Dr. Sotomayor expressed reservations, for example, about the state of the art with respect to the nature of bilingual/bicultural treatment approaches.

Finally, she pointed out the lack of knowledge about the causes of mental illness and substance abuse among Chicanos and other Hispanics and the need to integrate biomedical findings with social science findings. In addition, she emphasized the lack of information with

respect to language usage, noting that language can be used as a tool of social control and that language usage is certainly an issue that elicits strong emotional responses.

A general group discussion focused on specific strategies appropriate to Texas that would address the current funding crisis, while simultaneously laying the groundwork for solid planning in order to develop future mental health policies sensitive to the needs of Mexican American communities. The goals of the conference were to identify the current directions of mental health policies and responsive service delivery for Mexican Americans in Texas. The extensive dialogue and interaction among conference presenters and participants indicates the utility of bringing together mental health service workers and representatives from the governmental and public sectors to address Mexican American mental health concerns.

Mexican American Advocacy Association To Form

An ad hoc steering committee to develop a formal association of mental health and/or human service providers, administrators, planners and researchers emerged following the summary session of IDRA Mental Health Research Project (MHRP) Conference, the theme of which was *Mexican Americans and Mental Health: Issues to Action*. A challenge was made to conference participants to identify mental health advocates who would move the MHRP's research findings into the policy arena, thereby affecting the legislative and programmatic changes necessary to ensure quality mental health services for Mexican Americans.

Group discussion following the conference closure reached the conclusion that an advocacy association was necessary to inform the public and decision-makers about the need for improved mental health services. Three major issues identified as requiring immediate attention were:

1. informing the Mexican American Caucus in the Texas Legislature about mental health issues;
2. preparing Mexican American communities to respond proactively in order to ensure that their needs are addressed in the Texas block grant allocation process; and
3. ensuring that there will be Mexican American input to the process which will undertake the revision of the Texas Mental Health Code concerning patient rights during the interim Legislative Session.

Volunteers from the group offered to serve as an ad hoc steering committee to initiate the organizational process and to communicate with other potential members. Issues to be addressed by the group include: the ethnic focus of the association, its scope in terms of mental health or human services, its membership, the

name of the association, delineation of major goals and key tasks, the governance structure, and a membership recruitment process.

For more information, please contact a regional coordinator of the ad hoc steering committee in your area. The regional coordinators are:

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PLANNING STRATEGIES FOR MENTAL HEALTH SERVICES FOR MEXICAN AMERICANS

by Carmen Carrillo, Ph.D.

Planning for mental health services must involve two distinct levels of planning — policy development and program development. Policy development refers to planning efforts geared towards macro-perspectives such as national, state or county level standards for services. Program development planning refers to the planning effort needed to implement programs on the local level. Although these two levels are related, they require different elements for success.

Two primary elements, ideas and money, are essential for policy development. Ideas require technicians from a variety of disciplines who can interpret reality from their disciplinary frameworks and forge those interpretations into forceful policy statements. There are increasing numbers of qualified Mexican American technicians in the areas of fundraising, proposal writing, statistical analysis and the social sciences. The other element, money, is fundamental to the establishment of policy, since there is no sound policy that is not backed by dollars. In the public sector these dollars are controlled by budget language in legislative appropriations acts.

Program implementation requires two different elements — technical expertise (including leadership) and feedback mechanisms to the community and its elected officials. Many Mexican Americans have developed expertise in a number of areas relevant to mental health service delivery: management, program development, evaluation and direct services. Mexican Americans also enjoy a unique advantage in developing feedback mechanisms which ensure that programs receive information from Mexican American communities and that those communities are aware of the possibilities for maintaining and shaping programs. These skills are essential, particularly in densely populated Hispanic areas.

The key to effective planning is the planning *process* and *participation* in that process. Mexican Americans must investigate the components of the planning process so as to be prepared to participate actively. Although the particulars vary in each state, county and local jurisdiction, each state develops a mental health plan, usually composed of aggregate county plans and other data. Mexican Americans must know the process intimately in order to be able to provide input into the plan, review the plan for its ethnic content, testify at hearings on the plan, and present and publish written comments.

In addition, the review of state mental health codes or administrative regulations provides an excellent opportunity to contribute input on issues of relevance to Mexican Americans. It is critical to put forth the time and energy to participate actively in these processes. It is equally important to encourage the participation of Mexican American civic and business leaders, academics, consumers and others. We need the contributions of many voices to forge effective input.

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Planning Mental Health Services

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Likewise, participation in advisory bodies, governing boards, and bureaucratic structures provides other avenues for input. To achieve this, the bodies, boards and positions must be identified, individuals eligible for participation must be recruited and supported, and frequent contact with those individuals must be maintained. Important here is the notion of expanding the range of active players, rather than relying on the same pool of persons time and time again.

What about content? What are the best methods and techniques to develop data which support issues of concern to Mexican Americans? There is extensive debate among evaluators regarding the merits of different approaches to needs assessment. Although it can be useful to develop data utilizing innovative or esoteric techniques, I offer this formula to make a case for culturally appropriate needs assessment:

$$c + s.i. \times c.i.n. = w.p.c.\$, \text{ where}$$

c = census data
 $s.i.$ = social indicators
 $c.i.n.$ = community-identified needs
 $w.p.c.\$$ = weighted per capita dollars

This is a simple and effective formula which includes a strong base with census data, modified by social indicators derived from demographic characteristics, refined and fortified by Mexican American community-identified needs which can be collected by means of public hearings or analogous methods. The resulting weighted per capita dollar allocations can be shaped into programs appropriate to Mexican American communities, whose needs may vary from area to area.

It is important to identify Mexican cultural norms which conflict with the rules of the policy development game as drawn up by the majority culture. Three principle norms are highly relevant: 1) a high sense of morality, 2) a deductive interactional style, and 3) a belief in the basic good of humanity. These three norms are related but merit separate discussion. A high sense of morality is rooted in the religious values instilled in Mexican Americans. This moral sense leads Mexican Americans to believe that the righteousness of a cause is self-evident and merits favorable consideration by others. Thus, it is not unusual for Mexican Americans to be baffled by the majority culture's failure to understand and accept the premises put forth in arguments concerning services for Mexican American communities.

A deductive interactional style is based on communication patterns in which sufficient facts are presented to allow the other to come to the same logical conclusions as the communicator. It is a sophisticated use of logic which is effective within the group, but often fails with others. Thus, Mexican American advocates whose personal style tends towards the rational rather than the emotive will be particularly frustrated when

litany of facts are researched and those factual aggregates do not result in speedy remedial actions.

Finally a belief in the basic goodness of human nature assumes that people ultimately do what is right, that consensus about what is right is possible, and that through educational efforts and humanitarian appeals, the objectives of Mexican Americans can be met. This value is, of course, in contrast to the Western models postulated by Freud and Machiavelli which emphasize man's selfish need to manipulate his environment in order to meet his needs for power either through sexual means or through active or passive aggression.

To participate effectively in policy planning and development Mexican Americans must be aware of the influence of these cultural factors in the interactions inherent in the process. This is not to say that we must forsake our values at any moment, but rather to emphasize that the skills derived from those values are different from the skills applied by majority culture members to business interactions. When this distinction is understood, Mexican Americans can participate equally well in both the Anglo and the Mexican cultural milieus.

As we enter the 80s we must be prepared to enter the critical social policy debates engaging the country. In what kind of a society do we want to live? How do we want to deal with those less fortunate who suffer from mental illness or mental retardation? Where do we want to put our tax dollars — in the criminal justice system or in mental health/mental retardation centers? Why?

These questions are far from academic, since they are germane to the two social philosophies currently in confrontation: the free market versus the planned economy. Free market philosophy is capitalist in nature and emphasizes private control as well as private responsibility. Planned economies are socialistic and emphasize state control (through law and regulation) and state responsibility. A current national consensus is that FDR's New Deal approach to the country's economic problems went from experiments to remedies to expectations to white elephants. For Mexican Americans, another way to look at the situation is that the relative privilege of the American worker in relation to his or her counterpart in Third World countries must de-escalate as technological and political development in countries like Mexico increase. Involved are not just domestic economic issues, but international trade balances and, ultimately, East-West relations.

It is imperative, therefore, that we not get caught in a tragically ironic situation. Such a situation would be that now that Mexican Americans have developed technical skills in planning, budgeting, administration, and service delivery; now that we have models for the delivery of service; now that we can debate issues internally and with the majority culture; now that we're ready to descend on the train station; we find that the train has just pulled away from the platform!

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Conference Workshops

Address Key Mental Health Concerns

Participants at the "Mexican American Mental Health: Issues to Action" Conference were asked to choose major topics which were considered relevant to their professional interests and regional concerns. These topics were addressed in four concurrent workshops: Utilization of Services, Treatment Issues, Planning for Services and Patients' Rights and Advocacy. The workshops were designed to relate the findings of the IDRA Mental Health Research Project (MHRP) to key policy issues and to the need for action at the state level in the 1980s. Highlights of the workshop discussions are presented below.

Utilization of Services

The Utilizations of Services Workshop included presentations by Israel Cuellar, Ph.D., Director, Houston Hall, San Antonio State Hospital; Carlos Arce, Ph.D., Director, National Chicano Research Network, University of Michigan, Ann Arbor; and David G. Ramirez, Principal Investigator, IDRA Mental Health Research Project. Ramirez also served as the workshop facilitator.

Ramirez discussed the MHRP findings concerning utilization of community mental health center (CMHC) services by Mexican Americans. He asserted that the issues highlighted in the MHRP research were in some ways more important than the actual date of the study. The five key findings were that:

- Mexican Americans use *mental health* services at CMHCs significantly less than Anglos or Blacks.
- Mexican Americans use *drug abuse* services at CMHCs at approximately the same rate (no statistical difference between groups) as Anglos and Blacks.
- Mexican Americans use *alcohol abuse* services at CMHCs at a slightly lower rate (although not statistically significant) than Anglos or Blacks.
- Mexican Americans use *mental retardation* services at CMHCs at a slightly higher rate than Anglos but significantly less than Blacks.
- Mexican American children and youth (less than 21 years of age) use CMHC services significantly less than Anglos or Blacks; this finding is particularly significant given the high numbers of Mexican Americans in this age group.

Ramirez emphasized that future research on the "underutilization" phenomenon of mental health or

other social services by Mexican Americans must take into consideration the following factors: 1) the differential needs of distinct racial or ethnic populations; 2) the differential access to services of those populations, including private sector services; 3) the distinct ethnic composition of a geographical area or regional population; and 4) the differential age structures of distinct populations.

He noted that the methodology of service utilization studies has sufficiently developed to assist in clarifying the contradictory findings that have characterized past studies, and that previous underutilization research results were generally the result of the service system's characteristics rather than those of Mexican Americans.

In conclusion, Ramirez stated that in the next decade, independent of any change in CMHC programs or policies, more Mexican Americans will be provided services by CMHCs as a function of changes in the age structure of the Mexican American population. Therefore, the issues of compatibility between clients and services and the quality of services must be addressed in future research.

Cuellar discussed a number of factors related to utilization of mental health services by Mexican Americans. For example, he noted that if there is "overutilization" in a statistical sense, this does not mean that needs are being met. He also discussed the heterogeneity of the Mexican American population, and the importance of understanding and measuring the acculturation levels of clients with respect to implications for treatment.

Cuellar suggested that upcoming research should focus on defining and measuring the characteristics of effective services. Is the definition of effectiveness to be one of treatment compliance, of satisfaction measures, or of behavioral improvement? He noted that a program's provision of culturally relevant services may encourage a client to stay in treatment to avoid his or her poverty environment. Cuellar also discussed the shared negotiation of treatment definitions between the service provider and the client as an important feature of culturally compatible services.

Arce summarized the findings of the 1979 National Survey of People of Mexican Descent in the United States, which was undertaken by the Survey Research Center at the University of Michigan. He outlined the survey's goals of identifying help-seeking strategies of Mexican Americans and how they perceive their condition, as well as what they do about it. Dr. Arce reported that most of the respondents preferred familial help to other sources, and that there was an important age factor in distinguishing between the kinds of problems reported. Mexican Americans tended to seek out Mexican American helpers, and the formal helpers that were sought out were much more likely to be Spanish-speaking even if they were not Mexican American. Arce

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also noted that the frequency with which Mexican Americans seek out indigenous helpers suggests that they appear to be looking for service providers who understand Mexican American culture.

Treatment Issues

Panelists for the workshop on Treatment Issues included: Pablo Holguin, M.S.W., Coordinator of Mental Health Services, El Paso State Center for Human Development; John E. Brubaker, A.C.S.W., Executive Director, Austin-Travis County Mental Health Mental Retardation Center; Tom Owan, A.C.S.W., Project Officer, Division of Service Development, National Institute of Mental Health; and Sharon Sepulveda-Hassell, A.C.S.W., Research Coordinator, IDRA Mental Health Research Project, who was the facilitator for the workshop.

Sepulveda-Hassell discussed some of the MHRP findings on treatment issues, including the fact that many Mexican Americans at lower income levels appear to leave treatment earlier than other groups.

Holguin noted the continued need for bilingual/bicultural staff at all levels of service in most mental health programs, from volunteers to program directors and clinicians. He gave examples such as the practice of recordkeeping in English, which can serve as a barrier to staff who work with monolingual clients, as well as to client comprehension in terms of treatment plans. Holguin also emphasized the importance of identifying community resources.

Brubaker discussed a number of policy and procedural issues that impact on the design and actualization of an effective treatment program. He discussed the necessity of building a network among other service agencies, particular in the case of CMHCs which are located in multiple sites around the metropolitan area. He pointed out that significant real estate factors are too often overlooked. The accessibility and physical attractiveness of a facility can be crucial in attracting clients. The use of long-term leases can also demonstrate the commitment of a community mental health center to the community.

Brubaker also discussed the impact of policies or procedures that become so detailed as to create barriers to implementation of treatment programs. He pointed out the importance of fostering a balance between the autonomy needs of a CMHC board and the structural needs of the center's administration. A good deal of effort needs to focus on means of fostering staff creativity while providing clear guidelines as to their responsibilities.

Owan discussed alternative mental health service models and the need for rapid dissemination and evaluation of advocacy research efforts such as that of the MHRP. He emphasized the importance of dialogue

with other groups regarding effective psychotherapy and other treatment modalities for low-income people. Owan also suggested that the concept of neighborhood-based mental health programs must be promoted at the state and local levels if it is to survive in the 1980s.

Other issues which were discussed included concerns about the medical model which appears to be incorporating the concept of acculturation without acknowledging the need for alternative models of treatment and community intervention and the insufficient focus on prevention modalities. It was noted that bilingualism does not equate with bicultural treatment approaches. Emphasis was given to the strength of the Mexican American family as an untapped resource and support system for treatment plans and to the importance of "regionalizing" treatment strategies to conform to the different characteristics of Mexican American communities or even neighborhoods.

Planning for Services

Key factors relevant to Planning for Services were identified by: Carmen Carrillo, Ph.D., Director, Mission Mental Health Center, San Francisco; Eddy L. Herrera, M.S.S.W., Director of Health Planning, Texas Area 5 Health Systems Agency, Eules; and Alfonso Mirabal, M.S.W., Data User Service Officer, U.S. Bureau of the Census, Dallas. Sally J. Andrade, Ph.D., Project Evaluator, IDRA Mental Health Research Project, served as facilitator of the workshop.

Andrade outlined the context of the Reagan Administration's approach to planning, in that many presidential advisors view the national health planning effort as negative or even destructive. The Administration perceives federal regulation as inappropriate and ineffective and the federal coordination of planning as a usurpation of state and local responsibilities. Thus, the current federal budgetary restructuring proposed by President Reagan aims to phase out the entire planning program by 1983. One of the key issues to be addressed is how this will affect the concept of citizen participation in health care planning which has been a unique feature of the federal effort.

Carrillo focused on the policy dimension of planning for mental health services and discussed various techniques to document Mexican American consumer concerns. She also summarized various organizational activities in California that seek to generate advocacy for Mexican American mental health issues (see Carrillo's article in this issue for an expanded discussion of her presentation).

Herrera focused on the politics of health planning, emphasizing that planning is a political process. He discussed several key points that are necessary for an advocate to understand in order to be effective in the planning process. First, it is imperative to know what is possible, not just what is right, and to participate in bargaining, negotiation and compromise in order to

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achieve the goals of one's group. Second, politics involves the exercise of power in terms of both authority and influence. Third, advocates must recognize the importance of appealing to the self-interests of decision-makers. Fourth, one must realize that an individual's or group's interests are based on value judgments. Finally, values are not based on facts but rather on the interpretation of those facts and the meaning given to them. Herrera concluded by suggesting that advocates for more effective mental health services would have to organize in order to impact the planning process effectively.

Mirabal addressed the topic of community involvement in planning mental health services for Mexican Americans. He reiterated that there is no such thing as value-free social science findings or value-free health planning. Conflict and disagreements, therefore, are unavoidable; what must be learned is how to manage conflict constructively. Mirabal pointed out that the data from the IDRA Mental Health Research Project were massive and powerful, and when combined with the 1980 Census data, would provide all the information necessary to document the needs of Mexican American communities. What is required is a new agenda directed at developing new ways of addressing vital issues rather than the development of additional research data.

Mirabal reported an increasing level of sophistication in Mexican American communities. He suggests the need at this stage for assistance from service providers and administrators in focusing the available community energy in the barrio on the planning process. Networking across groups and regions must become the priority in order to revitalize self-help coping mechanisms in the 1980s.

The workshop also addressed the importance of Mexican Americans becoming proactive instead of assuming a reactive, defensive posture with respect to the block grant proposals. Concerns were expressed about the ongoing neglect of rural areas and the vulnerability of Mexican Americans with mental health needs in such rural communities. Several participants commented on the traditional importance of volunteerism and mutual help within Mexican American culture, noting that institutional responses were often non-supportive of the expressed interests of barrio residents. Suggestions were voiced about crossing boundaries, both ethnic and political, in order to foster positive change. Emphasis was also given to the need to develop an advocacy constituency with links to other social service providers.

Patient's Rights and Advocacy

The issues of Patients' Rights and Advocacy were addressed by Louis Kopolow, M.D., Chief, Patients' Rights and Advocacy Section, National Institute of Mental Health; Shirley Camfield, President, Citizens for

Human Development, Austin; Karl Menninger II, Attorney, Center on Developmental Disability Law, Kansas City, Missouri; and Alfonso Lopez-Vasquez, Research Associate, IDRA Mental Health Research Project, who served as workshop facilitator.

Kopolow focused primarily on advocacy: the need for it, the forms it can take and how it can function. Menninger discussed a specific sort of advocacy, that of legal advocacy and litigation on behalf of mental patients. Camfield spoke from the perspective of a volunteer and citizen advocate. Lopez-Vasquez presented an analysis of the generalizability of Title VI of the Civil Rights Act of 1964 from educational issues to those of mental health and patients' rights. The IDRA Mental Health Research Project will be producing a monograph on patients' rights and advocacy this summer which will describe and discuss in greater detail the topics of this workshop and a number of other issues.

Conference Closing Session Focuses Upon Action

The closing session of the Mental Health Research Project Conference involved a general workshop session focusing on Change Strategies and Legislative Issues. Panelists included Reymundo Rodriguez, M.S., Executive Associate, Hogg Foundation for Mental Health, Austin; Betty Button, M.S., Executive Director, Texas Senate Human Resources Committee; Sally Gardner, M.S., Administrator, Quality Assurance, Tarrant County Mental Health Mental Retardation Services, Fort Worth; and Adela Gonzalez Freymann, M.S., Division Director, Medical Assistance Program, Austin-Travis County Health Department. Rosa Maria Moreno, M.E., Research Associate, IDRA Mental Health Research Project, was the facilitator for the workshop.

Moreno opened the session by reiterating the goal of the conference — moving from issues to action, from research findings to policy formulation. She summarized major federal and Texas legislation affecting community mental health centers and the proposed funding reductions. She pointed out three approaches to change or goal attainment, suggesting that each had relevance for advocates of Mexican American mental health services:

- 1) the rational, or knowledge-based approach — i.e., if one presents a substantial body of facts to support one's position, one will be successful in the endeavor;
- 2) the human relations approach — relates to changing the attitudes and values of decision-

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makers, thereby convincing them of the validity of one's position; and

- 3) the power-base approach — entails the development of one's own power-base, or constituency and influence, in the policy-making structure and process.

Rodriguez noted that tactics of the past — intimidation, emotionalism or gross generalization — no longer had validity or utility in the 1980s. He emphasized the importance of careful research and conscientious strategizing, pointing out six key mental health issues which will remain paramount at the federal level in spite of the proposed changes by the Reagan Administration: health promotion, primary prevention, early identification and detection, crisis stabilization, treatment from a growth and development perspective, and maintenance of the impaired.

Button commented on the lack of Mexican American representation in the state planning process and the early stages of legislative committee work. She urged participants to get involved in legislative process and budgetary preparation work by: taking a more active role in local CMHC planning; educating CMHC executive directors about Mexican American issues; joining with other health and social service providers to discuss priorities; networking with consumers in their communities; forming local associations for advocacy; impacting the revision of the Texas Mental Health Code; and in particular contacting State Legislators directly.

Gardner pointed out that a "cookbook approach" of locally created strategies was often required in order to foster innovative outreach programs when the state emphasis is on cost-effective clinic services. She emphasized that the ghettoization of Mexican American services in a mental health center must be avoided. Instead, advocates should work within the institution for appropriate services to Mexican Americans within all targeted program areas and not for categorical services identified for Mexican Americans.

Freyman focused on the opportunities that were possible for Mexican Americans in the next decade by pointing out the potential benefits of block grants for local communities if active, informed involvement of community representatives characterizes the planning and allocation process of block grant funds. Future strategies would involve the education of the Mexican American Legislative Caucus and other legislators, as well as the Governor's Office, about the IDRA Mental Health Research Project findings and the resources and needs of Mexican American communities in Texas. Freyman concluded by insisting that Mexican American mental health advocates must organize in order to have an impact at the state level.

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ty percent reduction in staff. This relates to positions in various programs throughout the Institute, however, and does not mean that employees now holding potentially affected positions will lose jobs. According to the NIMH Director, it is probable that "the ultimate extent of a reduction-in-force will be substantially less than it may initially appear" (Pardes, 1981). Nevertheless, all regional office positions will be phased out and those planning and administration activities terminated by the end of FY 1981.

Similar reorganizational concerns are being identified at the National Institute of Drug Abuse and the National Institute of Alcoholism and Alcohol Abuse. The impact of these transitions for representation of Mexican Americans and other ethnically and linguistically distinct populations at all levels of decision-making in the federal mental health bureaucracy remains to be seen.

Summary

Although it is not clear at the time this article goes to press what will be the specific Congressional decisions concerning funding and administrative structures for mental health and substance abuse, there is increasing recognition that the major goal of the Reagan Administration is a fundamental restructuring of the federal government's role in health and social services. Professionals and other individuals working in the arena of mental health clearly need to remain informed if they are to participate in this new decision-making process.

References

- Morris, Inc. *Health Systems Report*, 1981, 10:6.
- Morris, Inc. *Health Systems Report*, 1981, 10:7.
- Morris, Inc. *Health Systems Report*, 1981, 10:8.
- Morris, Inc. *Health Systems Report*, 1981, 10:9.
- Morris, Inc. *Health Systems Report*, 1981, 10:10.
- Morris, Inc. *Health Systems Report*, 1981, 10:11.
- Pardes, Herbert. Memorandum to all NIMH staff; Subject: Budget and Personnel Issues. March 24, 1981.
- Texas Department of Mental Health and Mental Retardation. *Resource Memoranda*, 1981, 9:5.
- Texas Department of Mental Health and Mental Retardation. *Resource Memoranda*, 1981, 9:6.

Texas Legislative Response

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known to key legislators and advocacy groups who have taken a leadership role in this area in the past. The laws governing the civil commitment process in Texas need to address such issues as due process, diagnosis and screening, and adequate legal representation as it impacts Spanish-speaking clients. In addition, the question of the client's right to treatment vis-a-vis the absence of culturally and linguistically appropriate services is one which needs to be addressed. A dilemma arises if CMHCs are expected to provide aftercare and continued support services to Mexican American patients released from state mental hospitals, but are not currently staffed, prepared, or willing to provide culturally and linguistically appropriate treatment and follow-up services.

The challenge of the coming years lies both with the com-

munity mental health provider and the Mexican American community. The CMHC staff will be faced with addressing the mental health problems and needs of Mexican American clients, and the Mexican American community must initiate active participation both in the local community and at the state level to ensure that the necessary quality and type of care will be available.

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Let us not waste our energies chasing the caboose. Let us not fight to resurrect tired, inefficient models. The times require that we be proactive rather than reactive. The times require that we organize into mutual interest associations to further our pursuits, package and market our products efficiently and effectively, and emerge victorious on behalf of the 20 million Hispanics that we aim to serve.



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